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ABSTRACT

This monograph is the second of a two-part report delineating state and local government activities and programs in the area of drug abuse. Presented here are the efforts of cities and counties to control drug abuse, accompanied by comparisons with state actions where appropriate. A survey instrument was developed by the Drug Abuse Council, Inc. and distributed in 1972 to 409 cities and 313 counties, nationwide. Survey results for cities and counties were analyzed separately and were then further subdivided for analysis by size and by region. The five topic areas of the report are treatment and rehabilitation, education, law enforcement, administration, and funding. A major finding included the identification of nearly 1,000 methadone maintenance patients under the age of 18--a surprisingly large number. Employment rates among individuals enrolled in state, city, and county operated methadone maintenance programs were found to be very low. The response by many public schools to student drug use was particularly disturbing, and while many jurisdictions provided statistics on the number of arrests for possession and sale of marijuana and heroin, few provided followup information on these arrests. (Author/PC)

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SURVEY OF CITY/COUNTY DRUG ABUSE ACTIVITIES 1972

CG 009 290

THE DRUG ABUSE COUNCIL, INC.

MS—8

SEPTEMBER, 1973

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FOREWORD

The Drug Abuse Council, Inc. is a private, tax-exempt foundation established in February, 1972 to serve on a national level as an independent source of needed research, public policy evaluation and program guidance in the areas of drug use and misuse. It is supported by the Ford Foundation, Commonwealth Fund, Carnegie Corporation, Henry J. Kaiser Family Foundation and the Equitable Life Assurance Society of the U.S.

Through its publications and other activities, the Council provides non-partisan, objective information and analysis and serves as a resource for those organizations and individuals searching for new, more effective approaches to nonmedical drug use in our society. For a complete publications list, please refer to the back of this report.

SURVEY OF CITY/COUNTY DRUG ABUSE ACTIVITIES 1972 is one of a series examining the efforts of the public sector to control and prevent drug abuse. A similar survey of state drug abuse control efforts has already been analyzed by the Council's staff and published in May 1973 as **SURVEY OF STATE DRUG ABUSE ACTIVITIES 1972.**

In December of last year, the Council published **FEDERAL DRUG ABUSE PROGRAMS**, a lengthy compendium and analytic description of federal efforts through July, 1972. This was circulated to public officials and interested private citizens as a working document for substantive response.

The city/county survey for the first time documents on a broad and uniform basis the involvement of local governments in drug abuse prevention, treatment and control. This information becomes increasingly crucial with the growing responsibility of the cities and counties to provide educational materials through the public schools, to establish treatment programs, and to coordinate efforts and goals with the various law enforcement agencies.

The Drug Abuse Council hopes that this survey will facilitate the exchange of such needed information. Local officials can compare their jurisdiction's activities with the overall responses as well as with those of other jurisdictions in their regions and those of comparable size. Federal legislation encourages increased cooperation and coordination of city and state efforts. The city/county survey can be used by state officials to more clearly understand current local activities, problems and objectives. Both federal and state officials can utilize the analyses herein to formulate more flexible policies with respect to cities and counties of varying populations, regions and needs.

The Council staff welcomes inquiries from public agencies concerning specific survey findings. All the information is coded and computer retrievable. Thus, information more detailed than reported here can be made available upon request at a nominal charge, insofar as the confidentiality of individual responses is not jeopardized.

The high response rate to the survey was gratifying, indicating a shared belief that the collection, analysis and dissemination of this information will increase the effectiveness of the public's response to drug use and abuse. The Council would like to thank the staff of the International City Management Association, particularly Mary Ann Allard and Stan Wolfson, for their work throughout the project. Our sincere appreciation must also go to the city and county personnel who completed the lengthy survey forms and made this report possible.

The report was prepared by Peter Goldberg, John Sessler and Deborah Marks Danielson of The Drug Abuse Council staff, with the assistance of Jean Johnson.

I

INTRODUCTION

This monograph is the second of a two-part report delineating state and local government activities and programs in the area of drug abuse. Based on a survey designed by The Drug Abuse Council and conducted by the International City Management Association, the first report[1] examined the activities of state governments. Presented here are the efforts of cities and counties to control drug abuse, with comparisons with state actions where appropriate.

Prior to this survey there had been no systematically accumulated, accessible information regarding drug abuse-related programs and philosophies of state and local governments. Indeed, for most local jurisdictions, it was not even known to whom a questionnaire should most properly be sent. As with the state survey, The Drug Abuse Council's purpose was not to generate precise financial and statistical data. Rather, the goal was to develop a general understanding of program needs and policy objectives and to uncover heretofore unrecognized or unsubstantiated problem areas requiring further investigation. Finally, by analyzing certain questions appearing on both the state and local surveys in tandem, it was hoped to gain some insight into state-local relationships and into perceptions each had of the other. The latter is of particular importance when one considers the relative roles prescribed for state and local governments by the Drug Abuse Office and Treatment Act of 1972.

An identical questionnaire used for both the cities and counties[2] was mailed in the fall of 1972 to all cities with a population exceeding 50,000 and all counties exceeding 100,000 (based on 1970 census data). This city/county survey was a slightly modified and abbreviated form of the state survey. The questionnaire was sent to each jurisdiction's administrative liaison with ICMA's Urban Data Service Center. From there they were forwarded to appropriate local personnel for completion. In order to facilitate routing of the questionnaire the survey consisted of four separable parts—coordination and funding, treatment and rehabilitation, education, and law enforcement. This approach varied somewhat from that used for the state survey. By federal law each state must designate a single state coordinating agency. The state survey could thus be mailed as one entity to that one agency for completion as that office deemed best. Because no such requirement exists for local governments the alternative approach was necessary (the survey did, however, reveal a number of local jurisdictions that were investing overall local coordinating responsibility in one person or office).

A local jurisdiction did not have to complete and return all four sections to be included in the analysis. Thus the return rates for each section varied. Returns were accepted until January 1973, approximately 18 weeks after the initial mailing. Second and third requests were forwarded to non-respondents.

The survey included 409 cities and 313 counties. For each section the response rates for the cities were higher than for the counties.

Table A

Overall Return Rates

SECTION	Cities Returning Survey		Counties Returning Survey	
	Number	Percent	Number	Percent
Coordination and Funding	229	56%	142	45%
Treatment and Rehabilitation	227	56%	142	45%
Education	235	57%	130	42%
Law Enforcement	238	58%	111	35%

In no instance did the local rates of return approach those of the states: 39 states, Puerto Rico and the District of Columbia (defined as states by Public Law 92-255) completed and returned the questionnaire. This can in part be explained by the following:

- The state survey was conducted in conjunction with the National Association of State Drug Abuse Programs Coordinators, whose members were the recipients of the questionnaire. No similar association exists for local government drug coordinators.
- A specific recipient was identified for every state questionnaire, thus eliminating to some extent bureaucratic routing and rerouting. This was not the case for the cities and counties.

[1] *Survey of State Drug Abuse Activities: 1972* (Washington, D. C.: Drug Abuse Council, 1973), pp. 1-38.

[2] Appendix A.

- The drug abuse activities of every state are required to be somewhat coordinated in order to receive federal planning funds. This coordination makes completion of survey questionnaires an easier task. Again, similar coordination is not federally imposed upon the cities and counties.

Nevertheless, the response rate for the city/county survey was gratifying, especially in view of the length and complexity of the questionnaire.

Survey returns for the cities and counties were analyzed separately. Responses were further subdivided for analysis by size (as defined by population) and by region (Northeast, North Central, South and West). Detailed breakdowns of the return rates of each section by size and region for the cities and counties appear in Appendix B. Some of the significant variations to consider include:

- Return rates were higher from the larger jurisdictions than the smaller ones. Cities with populations between 250,000 and 500,000 had a consistently higher rate of return, never dipping below 70%; those with populations between 50,000 and 100,000 had a consistently lower return rate, never exceeding 55%. This difference may be attributed, in part, to the likelihood that larger cities are more frequently confronted with drug problems and are therefore more likely to have a person or office capable of responding to the survey. Responses from the larger and smaller counties showed less of a difference in return rates, although there was a direct relation between greater population and higher response rates.
- Regionally, jurisdictions in the West were the most frequent respondents. In the Northeast region the cities had the lowest response rate whereas the county returns were comparatively high.
- The highest rate of return in any subcategory was 83% among the cities between 250,000 and 500,000 on the law enforcement section; the lowest rate of return in any subcategory was 27% among the North Central counties—also on the law enforcement section.

As with the state survey there are interpretative limitations to the city/county data. It is imperative to repeat some of the general caveats listed in the state survey, as well as introduce additional ones specific to this study.[3]

First, the survey questions were designed to elicit responses from the greatest number of cities and counties possible regardless of the specificity of the data provided. As a result, some survey questions may seem overly vague. This is consistent with the stated objective of developing a general understanding of the drug abuse activities of local jurisdictions.

Second, the fact that some of the survey questions were quite general raises the possibility of different interpretations by different respondents. Thus, the statistics for some questions may be imprecise. Again, this does not undermine the purpose of the survey. Wherever possible, patently incorrect responses were omitted in this analysis.

Third, even where the local jurisdictions were able to provide statistics, the numbers are of questionable accuracy. The state of the art of management and control in the drug abuse field is primitive, and very few local jurisdictions are able to test drug-related data regularly for reliability and validity.

Fourth, there is a potential problem that geographic overlap between some cities and counties could result in double counting on certain questions. Data from a local area could conceivably be counted twice if the area was part of both a city over 50,000 population *and* part of a county over 100,000 population. Although the computer was not programmed to compensate for such double reporting, a manually conducted check showed that such instances were very few.

Fifth, the responses to questions requiring aggregated totals were often skewed by a few large jurisdictions with particularly big drug problems. This problem becomes more pronounced when returns are analyzed by population and regional breakdowns. Normally, the effects of this would be specifically noted at each occurrence. However, because of the confidentiality of individual returns, it was impossible to delineate how certain questions were disproportionately influenced by the answer (or lack of one) from certain key jurisdictions. When this problem was evident, the questions were re-examined in ways which minimized the effects of individual aberrations.

Finally, the drug abuse field changes rapidly. The time lag between computer tabulations of the returns, staff analysis and publication is about six months. During this period there is likely to be some turnover in administrative and program personnel, accompanied by changes in program operations as well as budgetary allocations.

Taking these caveats into account, the survey results cannot always be construed as an accurate picture of the current drug abuse activities among the cities and counties.

This paper analyzes survey returns for all reporting cities and counties, with size and geographic breakdowns included when appropriate. The five topics covered are:

- Treatment and Rehabilitation
- Education
- Law Enforcement
- Administration and Coordination
- Funding.

The number of jurisdictions answering a particular question is indicated by (N=), which is likely to be slightly less than the number of jurisdictions returning any given survey section because not all respondents answered every question. Similarly, percentages in parenthesis refer to the proportion of the total respondents who answered that particular question.

[3] Those caveats which pertain only to the financial data are discussed in the introduction to the budget section.

II

TREATMENT AND REHABILITATION

In the last few years, the federal emphasis on treatment and rehabilitation of drug dependent persons has shifted from large national centers to the support of small community efforts. At the same time, allocation for treatment and rehabilitation programs has markedly increased both in total expenditures and as a fraction of all money spent on drug abuse. In this survey, treatment and rehabilitation programs were found to be in operation in 170 of the 214 responding cities (79%) and in 121 of the 133 responding counties (91%). Programs were in operation in all responding cities and counties with populations over 250,000. Of those cities with treatment programs 72, or 42%, reported they were directly operated by the local government; the corresponding statistic for counties with programs was 65, or 54%. As might be expected, the smaller cities tended to operate fewer programs.

The existence of treatment programs was made known through a variety of avenues: the school system (92% cities, 92% counties); the correctional system (85% cities, 83% counties); television and radio commercials (75% cities, 61% counties); and mailed brochures (54% cities, 44% counties).

PATIENT ENROLLMENT

In 127 cities nearly 30,000 heroin users were identified as being enrolled in a treatment program. One third of this total resided in the 11 responding cities with populations over 500,000. In 97 counties nearly 23,000 heroin users were identified as treatment program enrollees: 45% of this patient population resided in the 29 responding counties with populations over 500,000. Because of the possibility of geographic overlap (which persists throughout this section), the patient population figures may be inflated; the reader is therefore cautioned against combining the city and county estimates.

A breakdown was available on the reasons for enrollment for 23,678 of the patients in city programs and for 19,724 of the county patients (see charts on page 6).

The same question yielded three other findings:

- 27 cities (23%) and 20 counties (22%) reported using a civil commitment procedure;
- 53 cities (46%) and 33 counties (37%) reported using a criminal commitment procedure; and
- 47 cities (41%) and 31 counties (35%) reported using a pretrial diversion program.

Wherever both a civil and criminal commitment procedure existed in local jurisdictions, it was found that the cities relied more heavily on civil commitment and the counties more on criminal commitment. Furthermore, the majority of the 2,154 city patients civilly committed were in the smallest cities. Only ten people of this identified patient population were in the largest cities. These findings suggest perhaps that civil commitment is used only by those jurisdictions with excess treatment capacities.

Table 1 describes treatment modalities for all patients in the cities and counties for whom the information was available.

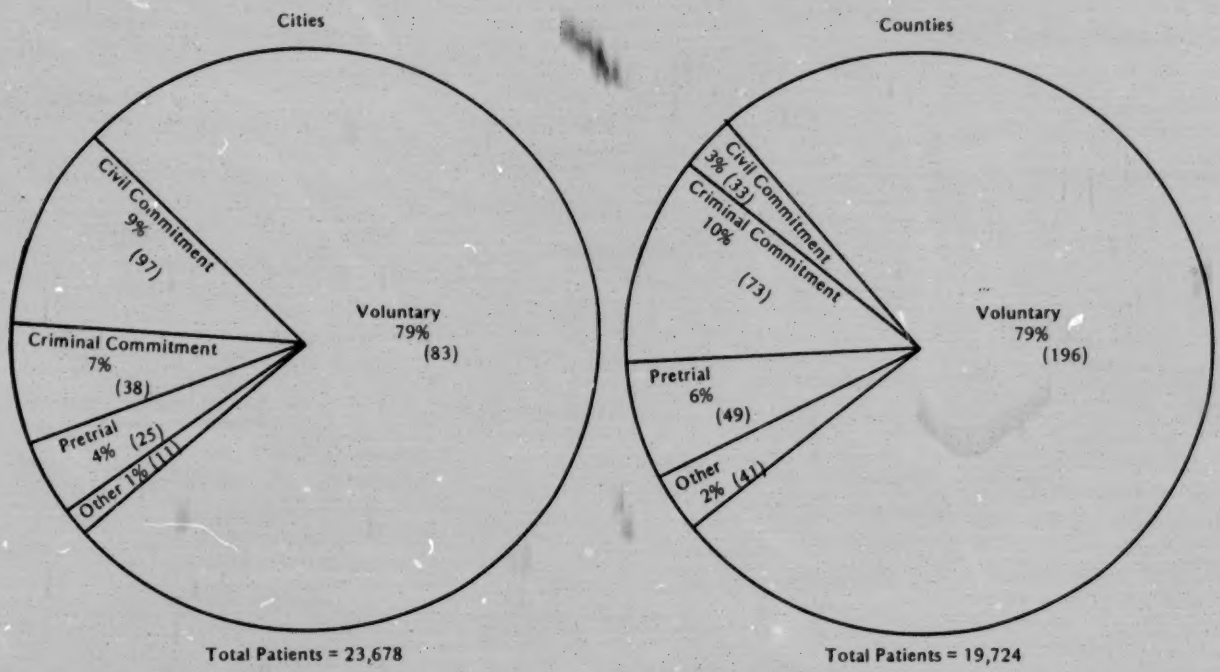
Overall, 46% of the patient population were enrolled in a non-chemical treatment modality (therapeutic community, outpatient abstinence, inpatient abstinence and detoxification) and 54% were enrolled in a chemical treatment program (methadone maintenance and narcotic antagonists). There was a marked difference between the cities and counties:[4] cities utilized chemical modalities less heavily (46%), while counties reported 66% of their patients in chemical programs. There was also a notable distinction in the regional breakdown. The North Central region reported a much heavier reliance upon methadone maintenance as a treatment modality than any of the other regions. Although skewed by one respondent, this finding for the North Central region was consistent with the state survey findings.

METHADONE MAINTENANCE

Because the use of methadone maintenance has become increasingly widespread and controversial, closer scrutiny

[4] This finding may be attributed, in part, to one very large county methadone program in the North Central region which skewed the results of the methadone related questions pertaining to descriptions of patient populations.

Reasons for Patient Enrollment



NOTE: Numbers in parentheses represent average patients per program where such exist.

Table 1
Summary of Enrollments by Treatment Modalities

	Cities			Counties		
	% Non-Chemical	% Chemical	Total	% Non-Chemical	% Chemical	Total
Total	54	46	35,396	34	66	23,071
Population:						
over 500,000	44	56	11,727	31	69	18,365
250,000–500,000	62	38	8,935	35	65	2,713
100,000–250,000	37	63	4,675	56	44	1,982
50,000–100,000	65	35	9,974	–	–	–
Region:						
NE	57	43	13,453	48	52	4,826
NC	32	68	3,137	11	89	8,488
S	52	48	9,824	54	46	4,174
W	58	42	8,911	41	59	5,562

NOTE: Total numbers of patients in each category do not equal grand total because of rounding in the calculations.

was given to this modality. Eighty-one cities and 62 counties reported methadone maintenance programs in operation. Again, a higher percentage of the larger jurisdictions had methadone maintenance programs in operation than did the smaller ones.

Prior to the recent federal regulations[5] governing minimum admission requirements to methadone maintenance

[5] 21 C. Federal Regulations 130.44 (1973).

programs, the following was reported by 126 jurisdictions (69 cities and 57 counties):

- 122 jurisdictions require some proof of addiction
- 117 jurisdictions require a minimum age (mean = 18)
- 101 jurisdictions require previous failures in abstinence (mean = 1 failure)
- 95 jurisdictions require a minimum number of years of addiction (mean = 1 year)
- 83 jurisdictions have a residential requirement

The rules governing take-home privileges for methadone patients were found to vary considerably—from never allowing the privilege to requiring less than one month's enrollment before granting it.

The following demographic analysis is based on approximately 14,000 methadone maintenance patients from 72 cities and nearly 15,000 patients from 60 counties.

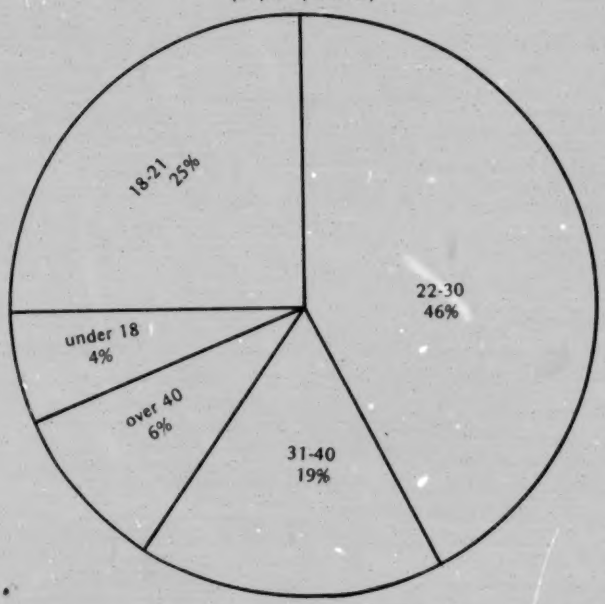
The ethnic composition of the overall patient population is described on pages 7 and 8.

The largest aberrations occurred in the North Central region, where the percentage of blacks in methadone maintenance was very high (the North Central region was also the one most heavily reliant upon methadone as a treatment modality), and in the West, where there was a high percentage of Mexican Americans in methadone maintenance.

The age breakdowns for all patients reported were as follows:

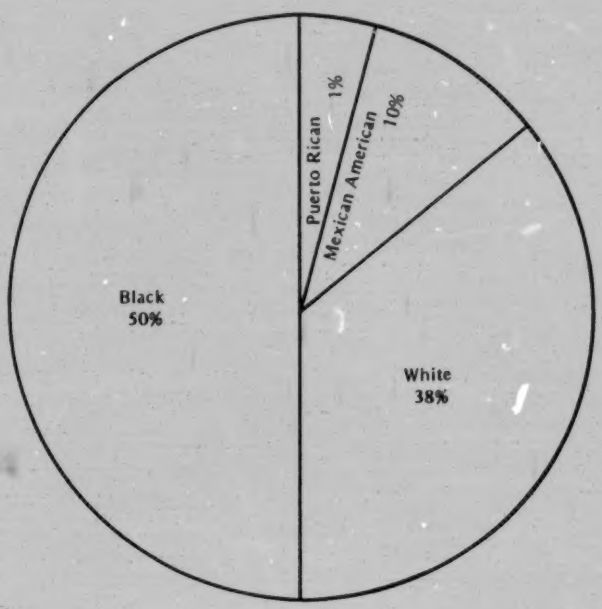
Age Distribution of Methadone Maintenance Patients

(23,391 patients)



Ethnic Composition of Methadone Maintenance Patients

(24,867 patients)



Twenty-four jurisdictions (11 cities and 13 counties) reported patients under 18 years of age enrolled in their programs. Nearly all of these patients under 18 (97%) were in county programs.

Waiting lists for entry into methadone maintenance programs were reported by just over one-half of the jurisdictions (72 of 132), with the largest localities reporting this item most frequently. The responses indicated that 9,000 people were on waiting lists in 61 jurisdictions, with considerable variations in reported waiting times.

Over 7,000 methadone patients in 90 jurisdictions were identified as receiving some type of vocational training and counseling.

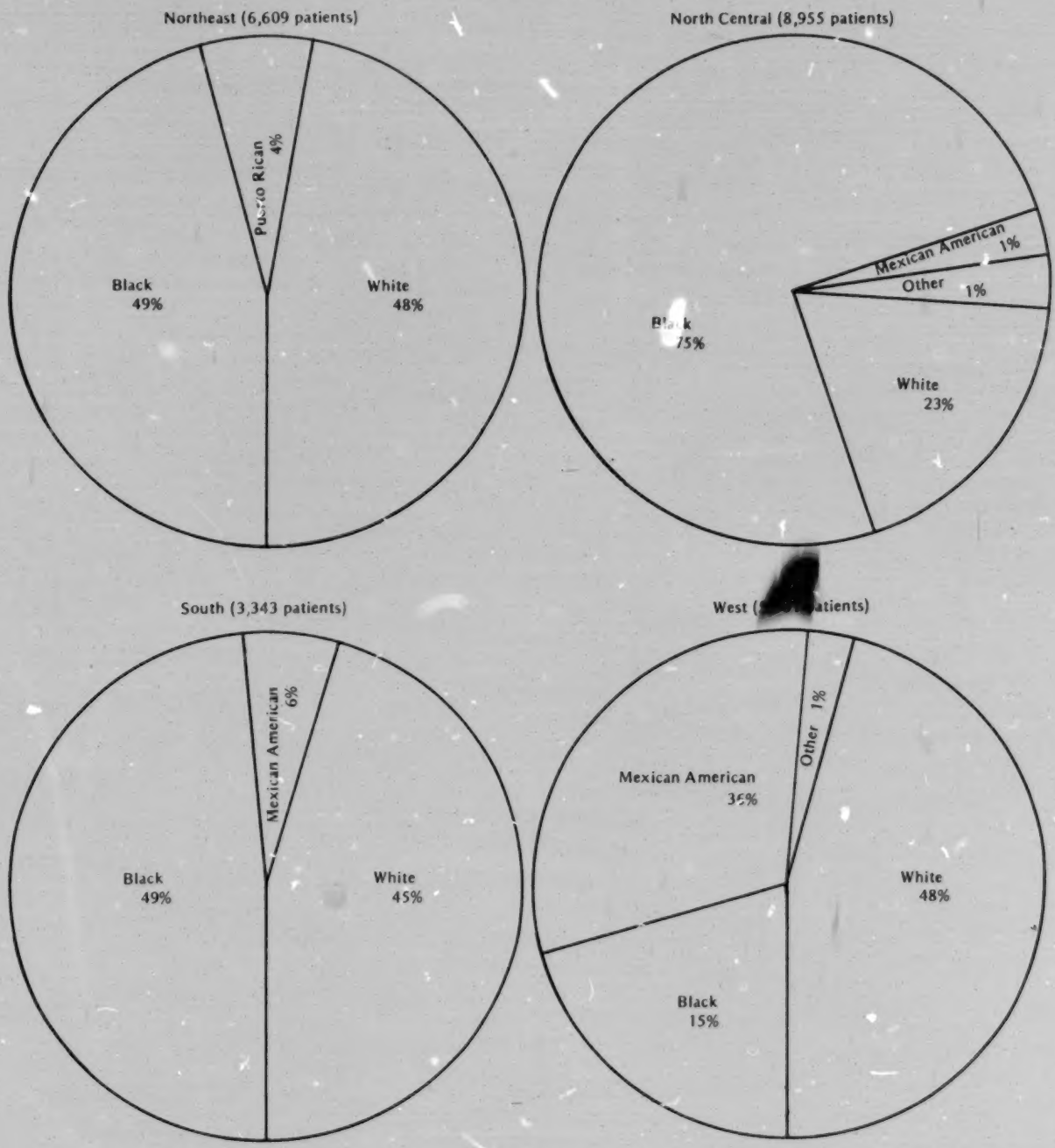
Other ancillary services made available to methadone patients included individual therapy (nearly 14,000 patients, the largest number of recipients of any service); group therapy (nearly 8,000); educational programs (4,200); and family counseling (3,300).

Forty-eight of 71 cities (68%) and 42 of 55 counties (76%) reported attempts to measure the effectiveness of their methadone programs.

Employment

Employment of methadone maintenance patients has been generally recognized as a problem. The survey revealed that 62% of the patients in city programs and 32% of those in county programs were employed. This gap may be

Ethnic Composition by Region



attributed to a few large county programs with particularly severe employment problems. Table 2 offers a more detailed breakdown of employment rates.

One factor which may explain the high unemployment rate among former heroin addicts is the attitudes of private employers. Because of the importance of employment in the rehabilitation process, the local drug abuse program coordinators were asked to characterize the generally prevailing attitudes among private employers toward hiring former drug abusers. The respondents were given five

Table 2

Employment of Methadone Patients

	Cities (N = 60)	Counties (N = 52)
Overall	62%	32%
Population:		
over 500,000	92%	27%
250,000-500,000	24%	59%
100,000-250,000	48%	68%
50,000-100,000	90%	
Region:		
Northeast	59%	70%
North Central	45%	9%
South	86%	45%
West	43%	50%

options ranging from enthusiastic to absolutely opposed. The results are shown in Table 3.

As shown in the above table, there is a nearly identical pattern of response from both the cities and counties: about 50% of each indicate "resistant" attitudes. This pattern is similar to that obtained in the state drug abuse survey.

Approximately one-quarter of the cities and one-third of the counties reported active involvement in special programs to hire rehabilitated drug abusers. Such activity was greater in the larger jurisdictions: over one-half of all reporting localities with populations over 500,000 were engaged in such programs. It was found, too (see Table 4), that the attitudes of private employers in these areas shifted slightly toward being more cooperative.

Table 3

Employers Attitudes Toward Hiring Former Drug Abusers

	Number Reporting	% Enthusiastic	% Cooperative	% Little Concern	% Resistant	% Opposed
Cities						
Total	171	1	13	33	51	2
Population:						
over 500,000	12	0	8	33	58	0
250,000-500,000	20	5	20	25	45	5
100,000-250,000	40	0	18	28	55	0
50,000-100,000	99	0	10	37	49	3
Region:						
Northeast	40	0	20	38	43	0
North Central	43	2	5	37	56	0
South	42	0	21	31	43	5
West	46	0	7	28	61	4
Counties						
Total	120	2	23	26	47	2
Population:						
over 500,000	31	0	23	26	48	3
250,000-500,000	26	4	23	23	50	0
100,000-250,000	63	2	24	27	44	2
Region:						
Northeast	37	3	27	19	46	3
North Central	25	4	12	20	64	0
South	33	0	30	27	39	3
West	25	0	20	40	40	0

Table 4

Contrast Between Employers Attitudes in Jurisdictions Involved and Not Involved in Hiring Former Drug Abusers

	Number Reporting	% Enthusiastic	% Cooperative	% Little Concern	% Resistant	% Opposed
Cities: Involved	44	2	23	30	43	2
Not involved	127	0	9	35	54	2
Counties: Involved	46	2	30	15	48	0
Not involved	74	1	19	32	46	3

Urinalysis

The responses to the questions pertaining to urinalysis constituted perhaps the most disturbing part of the survey.

The first related question dealt with the frequency with which urine samples were required to be submitted by methadone patients. The results are shown in Figure 1.

Approximately 60% of both the cities and counties required the submission of urine samples more than once per week. Six cities (N=68) and 11 counties (N=56) required a daily urine sample.

The second question dealt with the percent of samples that were actually analyzed: 63% of the cities (N=64) and 59% of the counties (N=54) reported analysis of every sample submitted, as did most of the jurisdictions requiring only one sample per week. About one-fourth of the cities and counties reported analysis one-third of the time or less. With the exception of five jurisdictions, which required daily samples of which 100% were analyzed, the percent of samples actually analyzed declined as the number of submissions per week increased.

The third question dealt with the cost of urinalysis. The average cost per analysis was $2.47 in the cities (N=50) and $2.71 in the counties (N=49). The relationship between the number of samples tested per week and the cost per analysis is displayed in Figure 2.

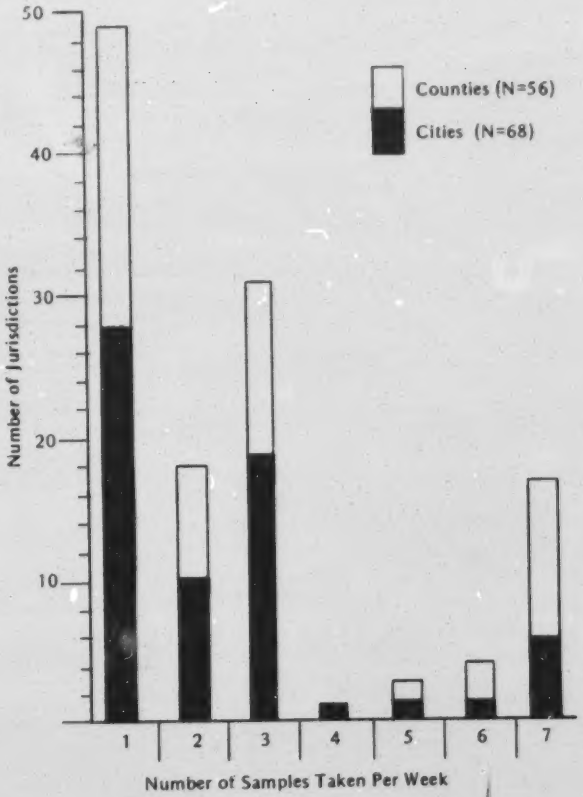


Figure 1. Frequency of Urine Sampling

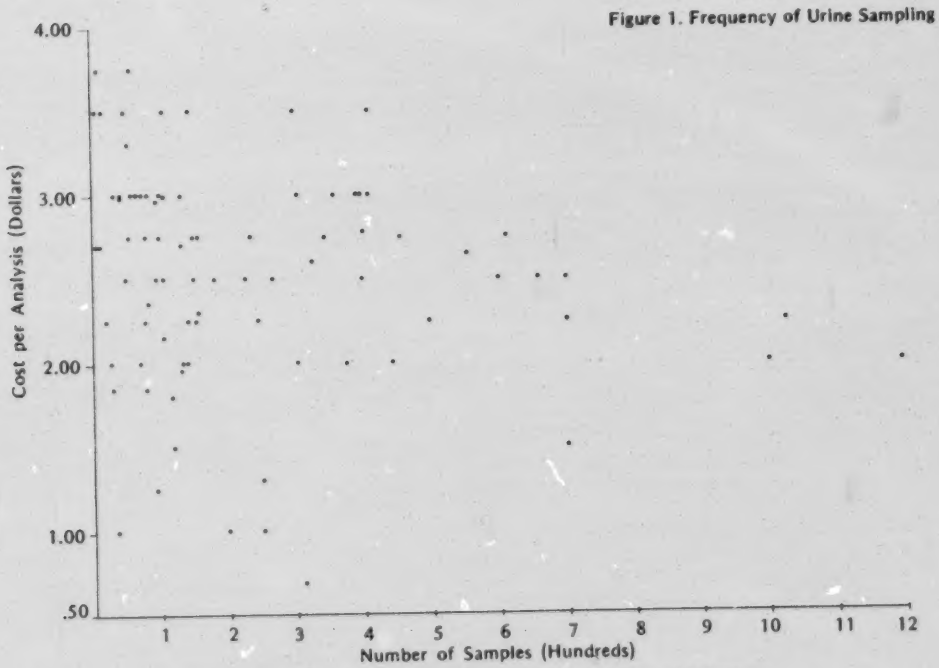


Figure 2. Relationship Between Number and Cost of Urinalyses

Some evidence for volume discounting is shown. The fact that the relationship is not more pronounced may be at least partially explained by the fact that variations in the types of urinalysis performed affect unit costs.

The annual cost for urinalysis was calculated using the following equation for each of the 92 reporting jurisdictions:

(# of patients in programs) X (sample taken per patient per week) X (fraction of samples analyzed) X (cost per analysis) X (52 weeks) = annual cost of urinalysis per jurisdiction.

The total annual cost of urinalysis was arrived at by adding the results from each jurisdiction and came to $4,721,508 spent annually to perform urinalysis on 23,386 patients.

If one assumes that this sample is representative of the entire methadone maintenance patient population, then the following can be projected:

- If there are 80,000 people in methadone maintenance then over $16 million is being spent on urinalysis annually.
- If there are 100,000 people in methadone maintenance then over $20 million is being spent on urinalysis annually.

This cost is particularly alarming in view of the questions now being raised about the effectiveness of urinalysis in monitoring.

III

EDUCATION

Drug education is generally considered the fundamental basis of any effective attempt to discourage the misuse of drugs. However, studies of the effectiveness of traditional programs that relied upon factual presentations or scare techniques indicate that the majority were not "successful." As a result there has been increased experimentation and innovation with new educational techniques. The survey results confirmed that no one educational approach is now widely agreed upon. Large disparities in the city and county returns were evident in the sources used for course materials, the manner in which they are presented, and the types of teachers assigned to the program.

Nearly every jurisdiction surveyed (91% of 227 cities and 88% of 128 counties) replied that some drug education program designed to affect students' attitudes toward drug use and abuse was in effect in the public schools. In 54 of these cities and 28 counties the program was not specifically labeled "drug education." In more than one-half of the reporting jurisdictions drug education courses were required by state law. Only one city and no counties reported a municipal requirement. Two-thirds of the 187 reporting cities and three-fourths of the 90 reporting counties offered adult education and training courses, provided by the public school system in more than one-half of these jurisdictions.

One impetus for the incorporation of drug education into the public school curriculum is the promulgation of a uniform drug education policy: 156 cities (78%) and 57 counties (52%) reported having such a policy. Such policies may range from the issuance of a minimum standard to the development of a full-scale plan. However, that more than 4 out of every 5 jurisdictions with a uniform drug education policy also reported having an administrator for the program might suggest that more than minimum effort was exerted to develop these programs.

BUDGET

The average school year budget for drug abuse education was $35,000 in the reporting cities (N=94) and $70,000 in the reporting counties (N=49). This mean figure, however, does not represent the vast majority of the respondents, a few cities and counties having reported very high budgets and thus skewing the overall average. When examined by quartiles one-half of the responding cities reported budgets under $12,000, and one-half of the counties had budgets under $40,000. It is interesting to note by quartiles the spending distribution patterns, as shown in Table 5, of the cities and counties when broken down by size and region.

Table 5

Drug Abuse Education Budgets by Quartiles

	Cities ($ in thousands)				Counties ($ in thousands)			
	(N)	25%	50%	75%	(N)	25%	50%	75%
Overall	(96)	5	12	41	(51)	10	40	86
Population (in thousands)								
over 500	(8)	20	76	100	(13)	44	86	146
250–500	(8)	25	68	102	(12)	12	33	60
100–250	(28)	5	11	27	(26)	4	12	49
50–100	(52)	3	9	25				
Region:								
NE	(22)	4	13	23	(14)	42	71	113
NC	(28)	3	10	45	(9)	1	40	49
S	(26)	5	10	34	(15)	8	12	23
W	(20)	5	25	68	(13)	13	40	86

Very few local jurisdictions indicated a direct federal funding source for drug abuse education projects. Of those listing a federal source, the Office of Education (15 cities and 10 counties) or the Law Enforcement Assistance Administration (10 cities and 11 counties) were most frequently cited.

CURRICULUM

Nearly one-half of all jurisdictions reported a drug education curriculum introduced in either kindergarten or first grade. The majority of the respondents also estimated

one hour per week devoted to drug education courses.

As did the states, the cities and counties reported using a variety of educational approaches in combination: factual information, decision making and value orientation were the most often noted. In one-half the jurisdictions school officials reported that the students actively participated in formulating drug-related school policies and educational programming.

The local jurisdictions also reported presenting drug education material through a variety of techniques. Except for field trips, each possible option was selected by more than half the respondents, with films and audiovisuals the most popular of all techniques.[6]

Local jurisdictions selected course materials from a number of sources: governmental, private and their own. These course materials were reportedly modified for minority students in only 30% of the cities (N=181) and 35% of the counties (N=86). The larger cities and counties reported modifications in a greater proportion than the smaller jurisdictions.

Although a variety of teachers were responsible for programming drug education courses, over half of the jurisdictions reporting indicated that the classroom teacher shared in this responsibility.

TRAINING AND COUNSELING

Three-quarters of both the cities and counties reported that teachers responsible for drug education courses received some training: 60% of the cities (N=84) and 51% of the counties (N=37) reported an initial training period of at least one week. Where training was mandatory, 68% of the cities (N=94) and 26% of the counties (N=19) also indicated that refresher courses were required.

Trained guidance counselors were available to students for individual consultations about drugs in 112 cities (60%) and 58 counties (62%). Although not all answered, those that did reported the counselors operated on a full-time basis.

Of those 112 cities with trained guidance counselors available, 63% reported permitting the guidance counselor to extend the privilege of confidentiality to students. A larger proportion of smaller cities allowed this practice than did the bigger ones. Of counties with trained guidance counselors, 53% of the 58 similarly allowed this privilege of confidentiality. This finding in the local jurisdictions conflicts somewhat with the results of the state survey: only 40% of the responding states reported this practice.

Nearly all of the local respondents allowed counselors to make referrals in acute drug cases.

PENALTIES FOR STUDENT DRUG USE

Of significant interest were the high school administrative actions generally taken against students caught either possessing or selling marijuana or heroin. For each of the four offenses the school administrators were offered the following list of possible actions they might take:

a) no action
b) suspension
c) dismissal
d) inform parents
e) referral for treatment
f) referral to police.

They could select as many of the actions as were appropriate. Table 6 details these actions in the aggregate for the cities and counties.

[6] The other options were: standardized curricula, assemblies, lectures by experts, student initiated research and group discussions.

Table 6

Possession/Sale of Marijuana/Heroin

	Cities and Counties Combined							
	Possession of Marijuana		Sale of Marijuana		Possession of Heroin		Sale of Heroin	
N =	240		240		229		229	
No Action	10		2		1		1	
Suspension	138		130		119		114	
Dismissal	24		60		55		73	
Inform Parents	191		173		171		170	
Refer to Treatment	68		48		81		62	
Refer to Police	125		186		180		198	
	City	County	City	County	City	County	City	County
N =	167	73	167	73	159	70	159	70
No action	5%	1%	1%	–	1%	–	–	1%
Suspension	62%	48%	57%	47%	55%	46%	53%	43%
Dismissal	10%	10%	25%	25%	26%	20%	33%	29%
Inform Parents	81%	75%	75%	66%	78%	67%	77%	69%
Refer for Treatment	31%	23%	22%	15%	36%	33%	30%	21%
Refer to Police	56%	44%	78%	77%	80%	76%	87%	86%

These findings demonstrate that:

- The possession of marijuana is treated more leniently than any of the other offenses.
- There is little noticeable differentiation in the actions taken against the offenses of the sale of marijuana and the possession or sale of heroin.
- For the most part the cities tend to take more actions against any of the offenses than do the counties.
- Across-the-board, referral to police is a far more prevalent action than referral to treatment, even when the offense is possession of heroin.

When the results shown in Table 6 were further broken down by size and region, there were few additional differences and no meaningful pattern of differences was discernible. The state survey had revealed that often no distinction was made between either the drug involved or the type of offense in determining the high school action to be taken against the offender. At that time the finding was considered tentative because education was recognized to be primarily a local responsibility. The findings of the city/county survey, however, reinforced those initial observations. According to local officials' impressions it was found that:

- 64 of the 187 cities responding (34%) and 30 of the 79 counties (38%) reported taking the same actions against students found possessing or selling either drug. Of these 64 cities and 30 counties:
- 49 cities and 25 counties referred offenders to the police regardless of the violation;
- 39 cities and 17 counties suspended offenders regardless of the violation.

In addition to these 64 cities and 30 counties:

- 21 cities and 8 counties reported no distinction made between the possession of marijuana and the possession of heroin;
- 62 cities and 25 counties did not distinguish between the sale of marijuana and the sale of heroin;
- 24 cities and 7 counties did not distinguish between the possession and sale of marijuana;
- 67 cities and 7 counties made no distinction between the possession and sale of heroin.

The number of jurisdictions falling into the first two categories, or failing to consider the two drugs differently, is particularly disturbing.

IV

LAW ENFORCEMENT

If the survey response rate can be construed as an indicator of either interest or responsibility, then it would seem that responsibility for drug abuse law enforcement rests primarily with the cities rather than the counties or states. Of the cities surveyed, 58% returned the law enforcement section—the highest rate for any city section. Only 35% of the counties surveyed returned the same section—the lowest rate for any county section.

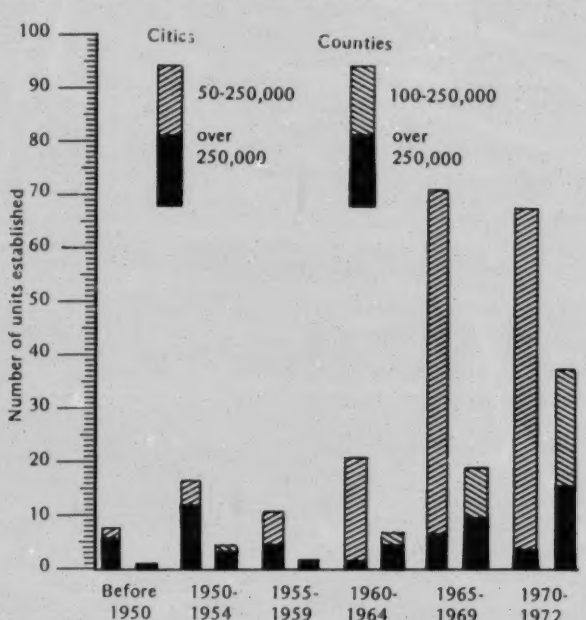
Of 235 responding cities, 88% (206) reported the existence of special narcotics units within their police forces. All 42 reporting cities with populations over 250,000 and 51 of the 52 cities with populations between 100,000 and 250,000 had these units; 40 of the 48 counties with populations over 250,000 also had them. Figure 3 displays the distribution of the year of establishment of these special narcotics units within the city and county police forces.

By and large, as illustrated in Figure 3, the cities established special narcotics units earlier than the counties, and the larger cities earlier than the smaller. If 1965 is used as a dividing line, then 79% of the responding cities with populations over 500,000 had already established special narcotics units within their police forces. Comparably, only 32% of the counties with populations over 500,000 and only 16% of the cities between 50,000 and 100,000 had also reported the establishment of these units by 1965.

Current participation in some kind of intergovernmental or interjurisdictional agreement related to narcotics law enforcement was reported by 154 city police forces (70%) and 59 county police forces (73%).

Fifty-one counties and 131 cities provided budgetary information on their special narcotics units. Overall, these jurisdictions spent in excess of $26 million annually on drug law enforcement efforts. The average annual budget for cities was $146,000 and for counties $141,000. There was a marked concentration of local narcotics law enforcement expenditures in the larger jurisdictions, with the 15 largest cities spending 59% of the total for all cities and the 15 largest counties accounting for 74% of the total county budgets. It was also found that both the cities and counties in the Northeast and West regions reported average annual law enforcement budgets of more than twice that reported by North Central and South jurisdictions.

Of equal interest to the expenditures made for drug law enforcement is the amount of manpower these efforts necessitate. In the reporting cities alone, nearly 4,000 law enforcement personnel could be identified as assigned full-time to drug control efforts. This number included 1,200 officers (in 197 cities), 1,200 patrolmen (in 112



Cumulative Totals

Cities 50,000 to 250,000	– 159
over 250,000	– 37
Counties 50,000 to 250,00	– 34
over 250,000	– 38

Figure 3. Years of Establishment of Special Narcotics Units

cities), 400 state drug enforcement officials (assigned to 80 cities), and just over 1,000 federal officers (assigned to 58 cities). One could add to this number 500 county-employed officers (in 70 counties) and 150 county-employed patrolmen (in 34 counties).

The combined law enforcement efforts of the cities and counties resulted in the confiscation of over 115,000 pounds of marijuana (180 cities and 59 counties) in the latest 12-month period for which the reporting jurisdictions had available statistics. Similarly, 89 cities and 32 counties reported the confiscation of just over 500 pounds of heroin.

Statistics were also gathered on the number of arrests made for the possession and sale of marijuana and heroin. Table 7 shows the results.

Table 7

Number of Arrests for Sale and Possession of Heroin and Marijuana

	Sale of Heroin	Possession of Heroin	Sale of Marijuana	Possession of Marijuana
Cities:				
Total arrests	7,998	36,300	6,000	48,600
% of arrests in the largest cities	57%	76%	19%	49%
Counties:				
Total arrests	1,517	2,530	2,448	12,921
% of arrests in the largest counties	51%	47%	28%	52%

More important than the number of arrests would be the generation of statistics depicting the outcomes of the arrests. Attempts were made to develop statistics on:

- The number arrested but directed to treatment before prosecution
- Number of prosecutions
- Number of convictions
- Average duration of sentence
- Maximum sentence given.

However, as with the state survey, the very low response rate to these particular questions precluded any meaningful analysis of the data.

The lapse from time of arrest for sale or possession of heroin to the time of trial was reported by 175 cities and 70 counties. The overall distribution of the average waiting periods for both cities and counties, broken down by size, are displayed in Figure 4.

The counties generally reported shorter waiting periods than the cities, although two-thirds of all jurisdictions reported waiting times of between 3 and 6 months. At the far end of the spectrum, 18 cities and two counties reported average waiting times of over one year before trial in a heroin possession or sales case.

Responses from 141 cities and 49 counties revealed that 40% of both jurisdictions used plea bargaining in over 70% of the heroin possession and sales cases. On the other hand, plea bargaining was used less than 10% of the time in 21% of the cities and 27% of the counties. Generally, more frequent use of this procedure was reported by the larger jurisdictions.

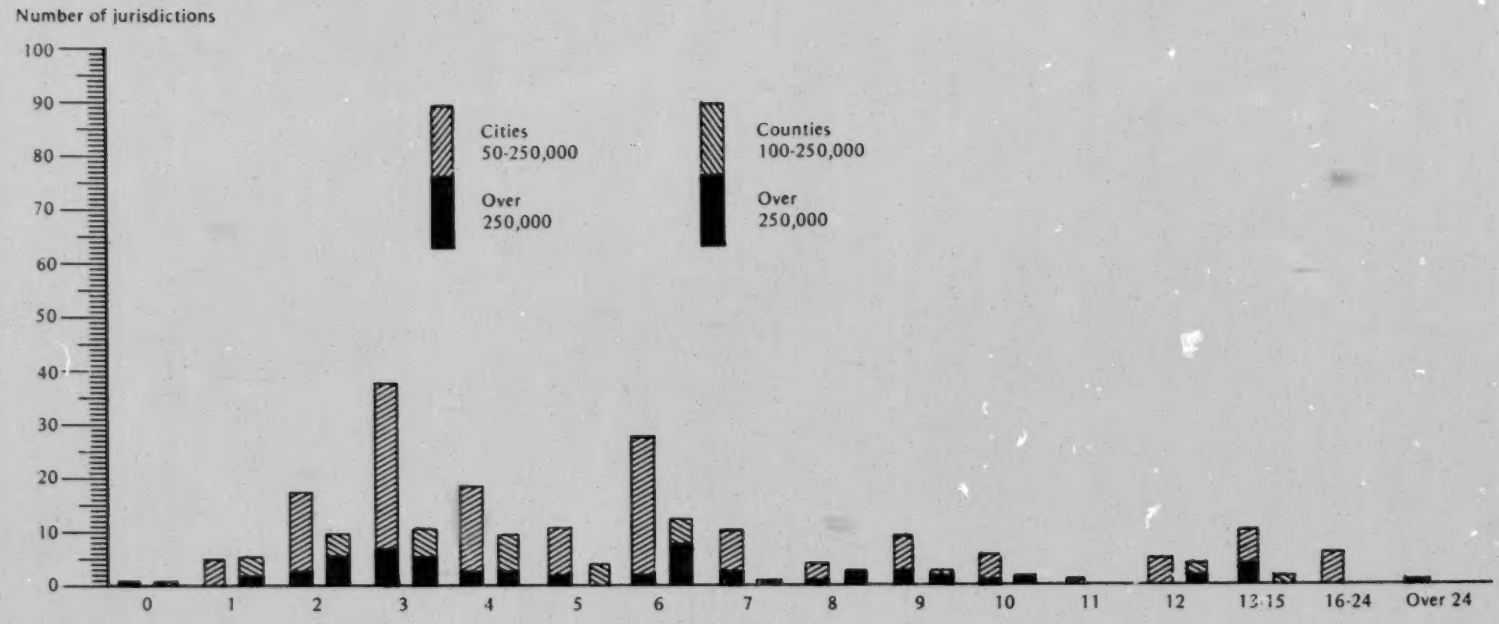
An investigation was made to see if there was any discernible relationship between reported waiting periods and the use of plea bargaining. Table 8 shows the results.

Table 8

Plea Bargaining vs Time to Trial

Time from arrest to trial (months)	% of Cases Using Plea Bargaining: 0 to 30%	31 to 70%	71 to 99%
Over 12	3 (18%)	1 (6%)	13 (76%)
7 to 12	7 (23%)	12 (39%)	12 (39%)
0 to 6	30 (34%)	25 (28%)	33 (38%)

As the table above suggests, there does appear to be a relationship between extended waiting periods and the frequent use of plea bargaining. The converse relationship, however, is not evident. This finding is somewhat different from that of the state survey, where no relationship at all was found.



Cumulative Totals:

CITIES:	0	5	20	51	67	76	102	110	113	120	125	126	131	138	144	144		
under 250,000	1	1	4	11	14	16	18	21	22	25	26	26	26	30	30	31		
over 250,000																		
COUNTIES:																		
under 250,000	1	5	9	14	21	25	30	31	31	32	32	32	34	36	36	36		
over 250,000	0	2	8	14	17	17	25	25	28	30	32	32	34	34	34	34		

Figure 4. Time Elapsed from Arrest to Trial

V

COORDINATION

This section should most appropriately be introduced with a reference to the federal coordinating requirements made of the states. Section 409 of the Drug Abuse Office and Treatment Act of 1972 requires each state to designate a single state agency to assume statewide coordinating responsibilities for drug abuse prevention functions as part of the effort to develop more effective drug abuse responses. No comparable federal mandate exists for the cities and counties, although the states in some instances may have enacted such legislation. Whether required or not, it was found that 132 cities (60%) and 106 counties (76%) do designate a person to assume overall responsibility for coordinating or guiding their jurisdiction's response to the drug abuse problem. Although one might expect that the larger cities and counties would be more likely to have drug coordinating offices or personnel, this presumption was not validated by the survey. The most frequent positive response was given by cities between 100,000 and 250,000, where 75% of the 48 respondents did have a coordinator. The size breakdowns, however, for the most part revealed the similarities between cities and counties in this respect.

Moreover, there was very little evidence to suggest that the position of drug coordinator was more often a full-time responsibility in the larger jurisdictions than in the smaller ones.

Overall, just over three-quarters of both the city and county drug coordinators did report some prior experience in the drug abuse area. This was most often the case in those cities with populations over 250,000: only three out of 24 reported no prior experience in drug abuse work.

In the cities there was a general emphasis on administrative backgrounds for the drug coordinator: 56 (41%) reported some such experience. Only 19 (14%) city drug coordinators reported a law enforcement background, all from cities under 250,000. There was less of an emphasis on administrative backgrounds among the counties, where 27% of the 105 drug coordinators reported such experience, 27% reported prior experience in the area of health, and 22% had a background in the social sciences; neither of the two latter fields were cited this frequently by the city coordinators.

An attempt was made to ascertain the relationship between the coordinating agency and the different drug program areas within the local jurisdiction. To describe this relationship, the coordinators were offered options ranging from communications and liaison to budgetary control; thus, the degree of their influence over the education, law enforcement, and public and private treatment programs could be characterized.

The returns suggested that in nearly all instances, in both the cities and counties, the coordinating office had little or no authority over the public education system's drug program or over the local law enforcement agency's narcotics control program. On the other hand, it was found that whenever a municipally sponsored drug treatment and rehabilitation program did exist in the local jurisdiction, 51% of the city coordinating agencies and 42% of the county coordinating agencies had budgetary controls. Not surprisingly, only 15% of the city coordinating agencies retained some budgetary control over private treatment and rehabilitation programs within their jurisdictions. This situation most likely arises when private programs are dependent upon government funding in order to continue operations.

It is fairly common knowledge that all levels of government have been actively involved in trying to deal with the problems of drug abuse.[7] Intergovernmental cooperation is important to the effectiveness and efficiency

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[7] Peter B. Goldberg and James V. DeLong, "Federal Expenditures on Drug Abuse Control," in The Drug Abuse Survey Project, *Dealing With Drug Abuse: A Report to the Ford Foundation* (New York: Praeger, 1972), pp. 300-328.

Survey of State Drug Abuse Activities: 1972 (Washington, D.C.: Drug Abuse Council, 1973), pp. 1-38.

Federal Drug Abuse Programs: A Report Prepared by the Task Force on Federal Heroin Addiction Programs and Submitted to the Criminal Law Section of the American Bar Association and the Drug Abuse Council (Washington, D.C.: Drug Abuse Council, 1972), pp. 1-531;

"Federal Programs for the Control of Drug Abuse," in *Special Analysis Budget of the United States Government Fiscal Year 1974* (Washington, D.C.: U.S. Government Printing Office, 1973), pp. 284-294.

of these efforts. Thus an attempt was made to measure the level of satisfaction on the part of local jurisdictions toward both the federal and state governments. Overall, 52% of the responding cities and 46% of the responding counties reported they were satisfied with the federal government in the area of drug abuse. The frequency of satisfaction expressed by the local jurisdictions toward the states was slightly higher: 57% for the cities and 54% the counties. Tables 9 and 10 portray the overall responses made by the cities and counties to this question.[8]

Generally, where a local jurisdiction expressed satisfaction with one level of government it did so also with the other; the converse was also true. For those jurisdictions displeased with only one level of government, the dissatisfaction was with the federal rather than the state government by a margin of almost two to one.

The cities, when broken down by size, revealed little differentiation in their satisfaction with the federal government. However, only 12 out of 30 cities (40%) with populations exceeding 250,000 expressed satisfaction with their state governments, whereas 78 out of 129 cities (60%) with populations between 50,000 and 250,000 did. The counties showed little differentiation in their attitudes when broken down by size.

With the exception of the West counties, which showed a slightly higher than average percent of satisfaction in their relationships to both the federal and state governments, there were no discernible regional differences in either the city or county responses to these questions.

The most dramatic differences in satisfaction are apparent when the attitudes of the central cities are compared to those of the suburban cities. Tables 11 and 12 show this contrast. Most noticeable is that 73% of the suburban cities expressed satisfaction with their state government compared to 50% of the central cities.

Because of the importance of intergovernmental cooperation, a second attempt was made to further clarify the local jurisdiction's relationship with the state and federal governments. The cities and counties were given a scale of 1 to 5, ranging from "very good" to "not good," to rate their relationships in the areas of funding, technical assistance, communications, and accessibility. No attempt was made in this question to distinguish between the state and federal governments. Generally, the means of the local responses clustered around the middle of the scale in all four

[8] See Appendix C for tables depicting the response to these questions by cities and counties broken down by size and region.

Table 9

Cities Satisfaction with State and Federal Governments

State \ Federal	Satisfied	Not Satisfied	Total
Satisfied	66 (42%)	24 (15%)	90 (57%)
Not Satisfied	16 (10%)	53 (33%)	69 (43%)
Total	82 (52%)	77 (48%)	159

- 52% are satisfied with federal; 48% are not.
- 57% are satisfied with state; 43% are not.
- 42% are satisfied with both.
- 33% are satisfied with neither.
- 10% are satisfied with federal, but not with state.
- 15% are satisfied with state, but not with federal.

Table 10

Counties Satisfaction with State and Federal Governments

State \ Federal	Satisfied	Not Satisfied	Total
Satisfied	44 (39%)	17 (15%)	61 (54%)
Not Satisfied	7 (6%)	44 (39%)	51 (46%)
Total	51 (46%)	61 (54%)	112

- 46% are satisfied with federal; 54% are not.
- 54% are satisfied with state; 46% are not.
- 39% are satisfied with both.
- 39% are satisfied with neither.
- 6% are satisfied with federal, but not with state.
- 15% are satisfied with state, but not with federal.

Table 11

Central Cities Satisfaction with State and Federal Governments

State \ Federal	Satisfied	Not Satisfied	Total
Satisfied	42 (38%)	13 (12%)	55 (50%)
Not Satisfied	14 (13%)	42 (38%)	56 (50%)
Total	56 (50%)	55 (50%)	111

- 50% are satisfied with federal; 50% are not.
- 50% are satisfied with state; 50% are not.
- 38% are satisfied with both.
- 38% are satisfied with neither.
- 13% are satisfied with federal, but not with state.
- 12% are satisfied with state, but not with federal.

Table 12

Suburban Cities Satisfaction with State and Federal Governments

State \ Federal	Satisfied	Not Satisfied	Total
Satisfied	24 (50%)	11 (23%)	35 (73%)
Not Satisfied	2 (4%)	11 (23%)	13 (27%)
Total	26 (54%)	22 (46%)	48

- 54% are satisfied with federal; 46% are not.
- 73% are satisfied with state; 27% are not.
- 50% are satisfied with both.
- 23% are satisfied with neither.
- 4% are satisfied with federal, but not with state.
- 23% are satisfied with state, but not with federal.

functional areas, by both cities and counties, regardless of size or region. The mean responses were as follows:

	Funding	*Technical Assistance*	*Communications*	*Accessibility*
Cities	3.1 (N=163)	2.9 (N=163)	2.5 (N=165)	2.6 (N=163)
Counties	2.8 (N=112)	3.0 (N=115)	2.6 (N=117)	2.4 (N=116)

Interestingly, however, and as tables in Appendix D delineate, the responses were distributed uniformly across the spectrum rather than in the typical bell shape.

The local jurisdictions were also asked to define to the best extent possible their financial and policy relationships with the states. Of 149 cities and 112 counties, 51% and 69%, respectively, reported heavy dependence upon state financial aid for operation of their drug abuse programs. On the other hand, only 24% of the cities and 23% of the counties reported that their states actively asserted policy control over local government programs. The cross tabulation of these two questions yields the matrices depicted in Tables 13 and 14.

When the question of financial dependency was considered by population, neither the cities nor the counties varied much from the overall average. Surprisingly, however, there was a strong regional variation: both the Northeast cities and counties more frequently reported a heavy financial dependence on the states, the counties returning a 76% positive response.

On the question of policy control, the larger cities tended more often to report setting their own policies for their drug programs in relative autonomy from the state. Ten out of 11 answering cities with populations over 500,000 and 14 out of 17 between 250,000 and 500,000 supported this characterization. In the case of the larger counties, however, it was found that the states actively asserted policy controls over local programs. As with the

Table 13

Cities Financial & Policy Relationship with the State

City Governments Policy Relationship to the State \ City Governments Financial Dependence on the State	Heavy	Not Heavy	Total
Dependence	29 (19%)	7 (5%)	36 (24%)
Autonomy	47 (32%)	66 (44%)	113 (76%)
Total	76 (51%)	73 (49%)	149

question of financial dependency, there were also surprising regional differences expressed on the degree of policy control exercised by the states: 43% of the Northeast cities reported their states actively asserted policy control; only 11% of the North Central cities, 16% of the West cities and 28% of the South cities answered similarly. The responses of the Northeast counties were not, however, noticeably different from the counties in other regions.

The identical question on financial and policy relationships between local and state governments was also asked of the states. The responses of each state were compared to those of the cities and counties within that state. As the findings below suggest, there is certainly no strong pattern of state/local agreement or disagreement evident (Note: if there is *no* relationship between the localities' and the states' perceptions of the financial dependency/policy control question, then approximately 50% agreement would be expected).

The findings were as follows:

- Within the 20 states reporting heavy local financial dependency, 62% of the cities (33 out of 53) and 78% of the counties (42 out of 54) agreed with the states' view.

Table 14

Counties Financial & Policy Relationship with the State

County Governments Policy Relationship to the State \ County Governments Financial Dependence on the State	Heavy	Not Heavy	Total
Dependence	20 (18%)	6 (5%)	26 (23%)
Autonomy	57 (51%)	29 (26%)	86 (77%)
Total	77 (69%)	35 (31%)	112

- Within the 12 states reporting that local governments were *not* financially dependent, 56% of the cities (22 out of 39) and 47% of the counties (14 out of 30) agreed.

- Within the 8 states reporting the exercise of policy control over local government programs, 43% of the cities (13 out of 30) and 33% of the counties (7 out of 21) agreed.

- Within the 24 states reporting that local governments operated their drug programs relatively autonomously, 77% of the cities (48 out of 62) and 76% of the counties (48 out of 63) agreed.

Two indicators remain of the level of coordination attained by a local jurisdiction in its efforts to control the problems of drug abuse: the development of a comprehensive plan and the preparation of an annual report. Of the 170 cities responding, 50% reported that a comprehensive plan for drug abuse response had been developed. However, only five of the 13 cities with populations over 500,000 had such plans. Comprehensive drug abuse plans were also reported by 73% of the 114 counties responding. Annual reports on the state of the drug abuse problem within their jurisdictions and on local efforts to control it were reportedly prepared by 59% of the 138 cities and 70% of the 106 counties responding. The survey did not address itself to the quality of either the comprehensive plan or the annual report.

VI

FUNDING

In contrast to the insufficient responses to questions on drug abuse funding yielded by the state survey, the returns from cities and counties were approximately 25%, a response rate adequate for at least a rough analysis. Functional breakdowns of governmental budgets generally, however, are plagued by inexactitude. Even more difficult to develop are accurate breakdowns within the drug abuse budget itself. Additionally, not all jurisdictions were able to report for the same twelve-month period. Thus, recognizing these obstacles to obtaining precise figures, the questionnaire asked only for *estimations*.

With the acknowledgement that these budgetary figures are not sufficiently accurate for accounting purposes or strict budgetary analyses, they are nevertheless of interest and value, especially as a reflection of priorities within the area of drug abuse throughout the country. However, the value extends beyond the national level. The following analysis should enable local jurisdictions to compare their drug abuse priorities with the priorities of other jurisdictions of similar population size and regional location.

Three primary questions were asked pertaining to drug abuse-related funding and expenditures:

- How much total money is estimated to be spent annually within your jurisdiction for drug abuse response?
- What percentage of the funds are received from the following sources:

  Local jurisdiction?

  State?

  Federal?

  Private and other?
- What percentage of the funds are expended for the following functions:

  Law enforcement?

  Treatment and rehabilitation?

  Education, prevention & training?

  Research?

  Planning and coordination?

The analysis will consist of three sections: first, a discussion of overall drug abuse budgets focusing on means, medians and quartiles; second, an analysis of the sources and distribution of the reported drug abuse budgets, confined only to the responding jurisdictions; third, a discussion on national projections for all cities above 50,000 and all counties above 100,000, based upon the size and regional characteristics of the actual respondents.

OVERALL DRUG ABUSE BUDGETS

The year in which funds were first earmarked in a local budget for drug abuse response can serve as an indicator of when that jurisdiction first acknowledged drug abuse as a problem. Earmarking of drug abuse funds is a fairly recent phenomenon: 70% of the local jurisdictions reporting (119 cities and 95 counties) did not have such funds allocated until 1970 or later, as Figure 5 indicates.

Nearly $75 million was identified as being spent annually for drug abuse by all 119 city respondents, yielding an average annual budget of $628,000. As might be expected, the average budget correlated with city size. The cities over 500,000 population reported an average annual budget of $3,224,000 (N=10), whereas cities between 50,000 and 100,000 averaged $125,000 annually (N=67). Regionally, the average drug abuse budget in the Northeast, South and West was about $750,000, contrasting sharply with the North Central region which reported an average budget of only $330,000 (Note: there was fairly even regional reporting).

The average annual county budget (N=99) was identical to that of the cities, $628,000, and also correlated strongly with county size. The largest counties (N=28) averaged $1,502,000 annually and the smallest (N=53) averaged $199,000 per year. Contrasted with the cities, the North Central counties reported the largest annual drug abuse budget of the regions. This might suggest that in the North Central region counties bear the primary responsibility for drug abuse programs.

Analysis of response distribution showed the mean

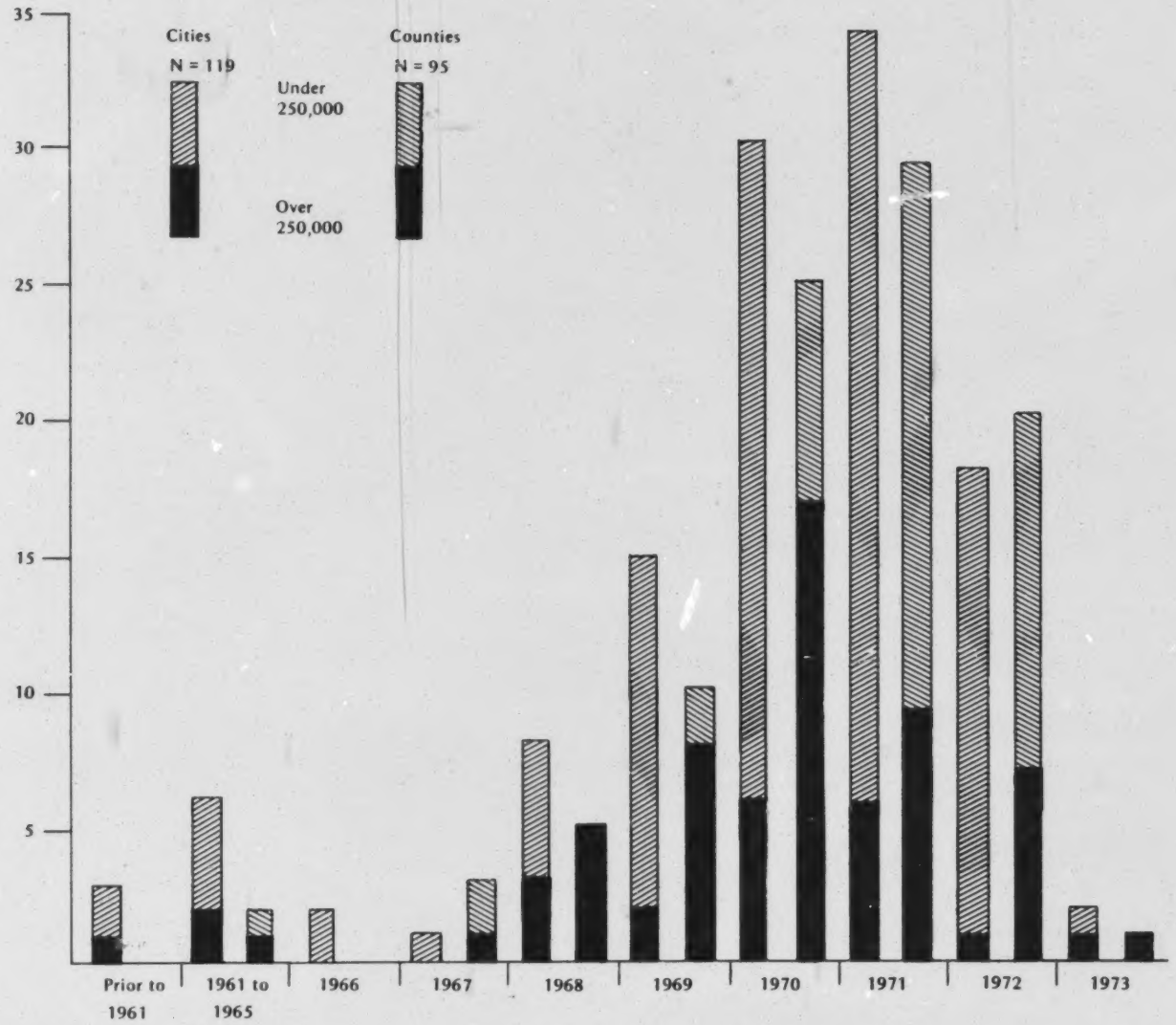


Figure 5. Year When Funds Were First Allocated for Drug Abuse

expenditure to be consistently larger than the median expenditures and in many cases to be larger than the third quartile expenditures. This indicates the mean budget is biased toward higher values by a few jurisdictions with very large budgets.

Table 15 shows the drug abuse budgets for cities and counties by size and by region.

SOURCES AND EXPENDITURES ANALYSIS

While the previous discussion of total budgets included all respondents to the first question, the discussion on sources and expenditures is based only on those jurisdictions that responded to all three budgetary questions (see page 25). If, for example, a city had answered the first two questions only, it was not included in this particular analysis. This sample is thus more selective and, therefore, the total average dollars reported in the previous section will not necessarily agree with those presented in this section. Charts a thru q summarize the findings regarding sources and expenditures of drug abuse funds, based upon the responses of 97 cities and 85 counties. The number in the large center box refers to the average annual overall drug abuse budget for a jurisdiction of that type. The sources and expenditures are shown in two ways: the average annual dollars received and expended[9] by the

[9] The totals may not always add up due to rounding in the calculations.

Table 15

Total Money Spent Annually Within Jurisdictions (in thousands)

	# Responding	Mean	1st Quartile	Median	3rd Quartile
All Cities	119	628	50	137	506
over 500,000	19	3224	1183	2000	3246
250,000-500,000	13	1368	417	850	1688
100,000-250,000	29	563	98	285	581
50,000-100,000	67	125	30	71	121
Northeast	29	807	43	100	469
North Central	34	330	48	94	346
South	26	735	46	272	783
West	30	700	64	158	400
All Counties	99	628	65	200	713
over 500,000	28	1502	527	1118	1500
250,000-500,000	18	532	125	234	300
100,000-250,000	53	199	38	105	234
Northeast	33	457	113	245	578
North Central	19	1070	57	200	465
South	25	364	52	130	518
West	22	804	56	450	1268

localities are shown in the smaller boxes and the relative distribution of these sources and expenditures are shown in the pies.

The absolute dollar value of the sources and expenditures of the drug abuse budgets declined as the population of the jurisdiction declined. The relative composition of these sources and expenditures, however, varied. On the average, the smallest cities received the least external support; in these jurisdictions local contributions constituted over one-quarter of the annual drug abuse budget. By comparison, local contributions in the larger cities made up only about 13% of their respective drug abuse budgets. The smallest counties were much more heavily dependent upon the state than the larger counties.

It is also of interest to contrast cities and counties of equal size. The total city drug abuse budget was about three times larger than that of the counties. However, the relative composition shows that the cities were generally more reliant than the counties upon the federal government; the smaller counties relied much more heavily upon the state governments than did the smaller cities.

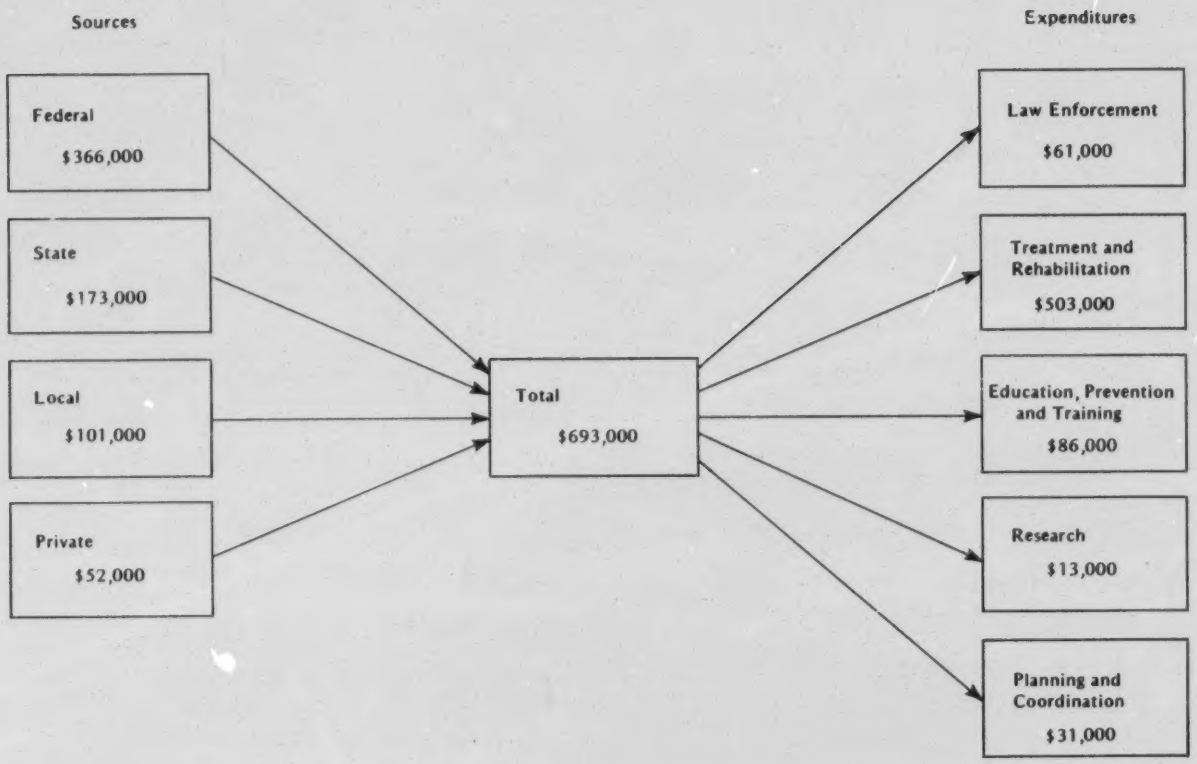
Treatment and rehabilitation expenditures constituted the majority of funds spent according to every breakdown considered. In the larger cities and counties, treatment and rehabilitation expenditures represented a larger fraction of the total budgets. This was particularly the case in cities over 500,000, as well as in the Northeast cities. In general, budgetary priorities suggest that the cities attach a greater significance to treatment and rehabilitation than do the counties.

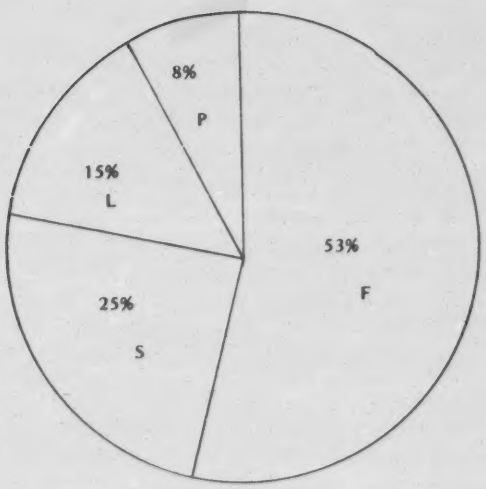
In absolute dollar terms, city law enforcement budgets declined as city size declined but increased relative to the total drug abuse expenditure. Law enforcement was not heavily emphasized by local jurisdictions in the Northeast. More importance was attached to law enforcement in the South and West, especially by the counties in those regions. In the North Central region, drug abuse law enforcement was found to be almost exclusively a city rather than county function.

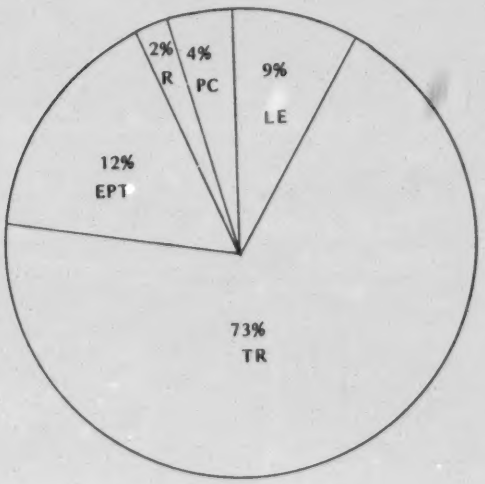
The role of education, prevention and training was most heavily emphasized by the smallest counties (28% as opposed to 13% of the budget of the largest counties). Otherwise the pattern seems fairly random. Contrary to federal spending patterns, our analysis indicates that on the average more money is spent on education, prevention and training than drug abuse law enforcement in both cities and counties.

In only one instance did research combined with planning and coordination exceed ten percent of a total drug abuse budget (12% in the smallest cities but only $13,000 annually).

a
All Cities
N = 97



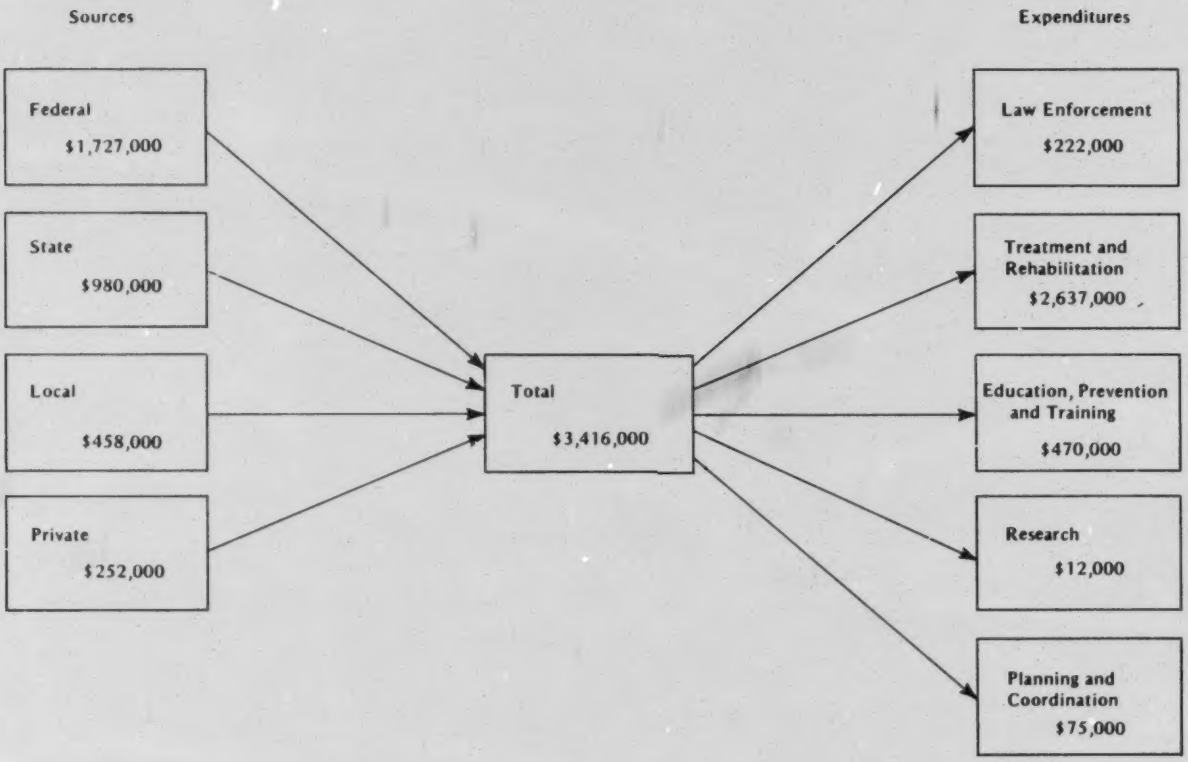


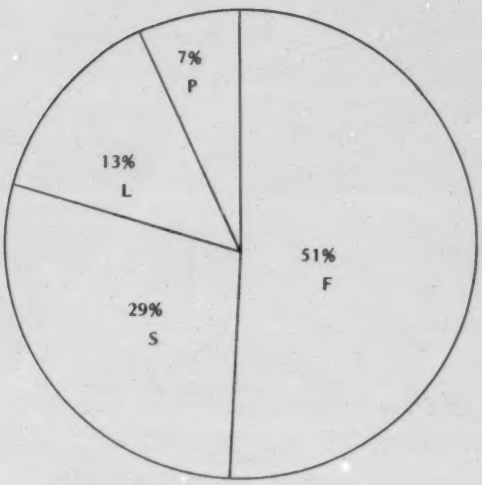


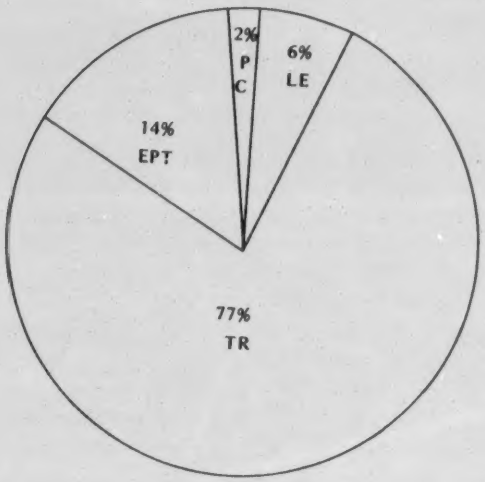
b

Cities: over 500,000

N = 9







c

Cities: 250–500,000

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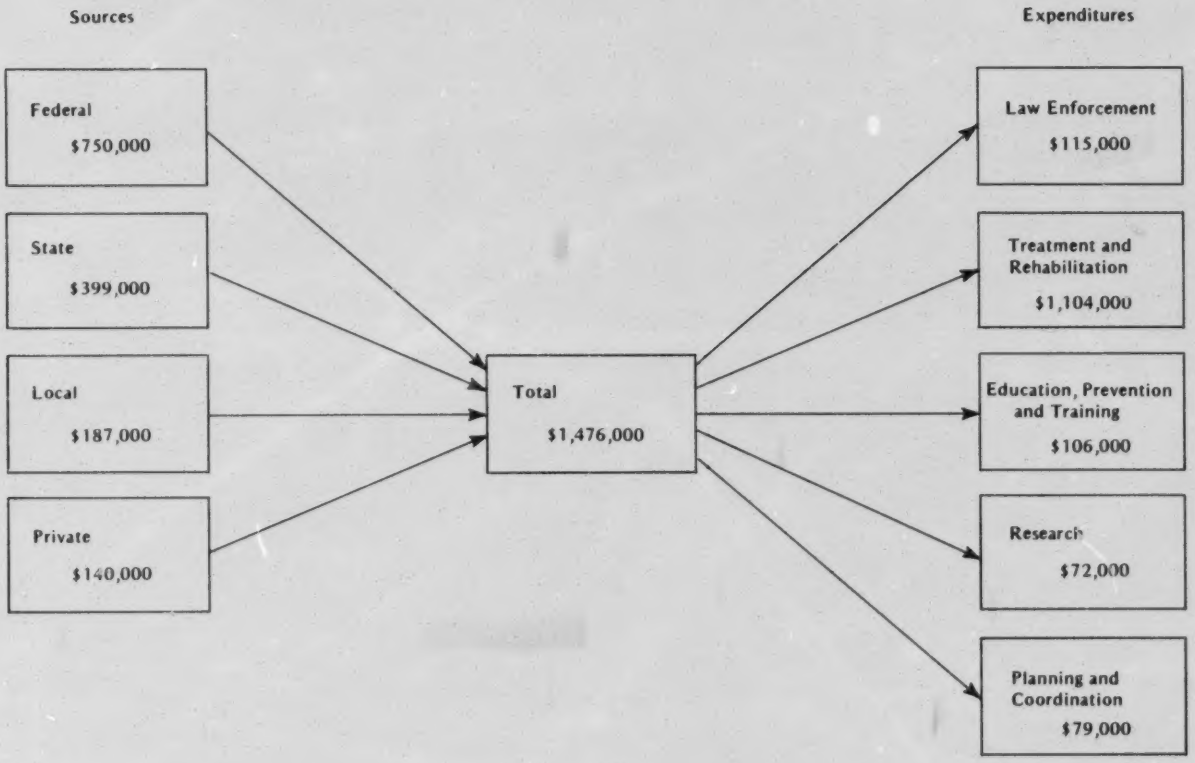

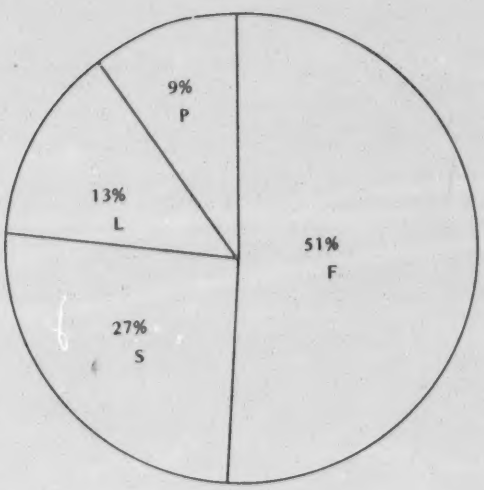

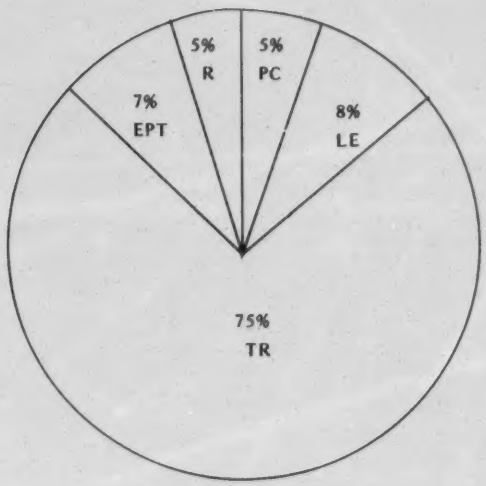

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Cities: 100-250,000

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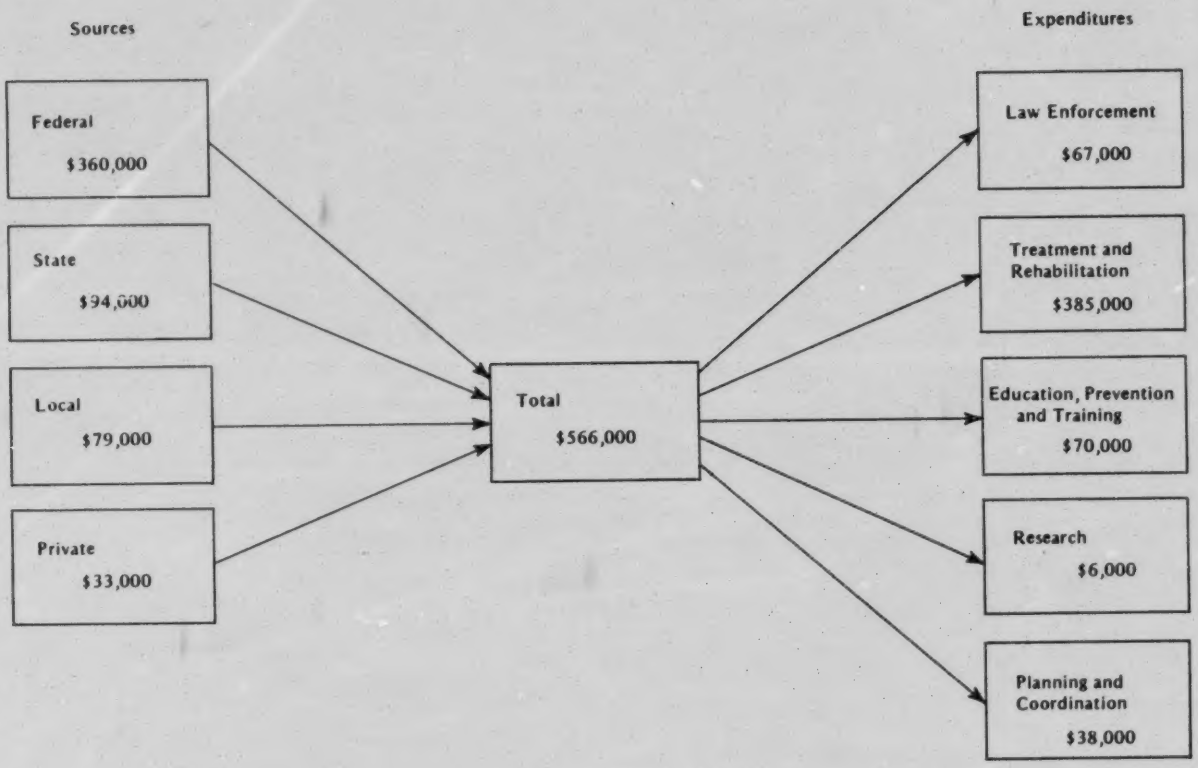

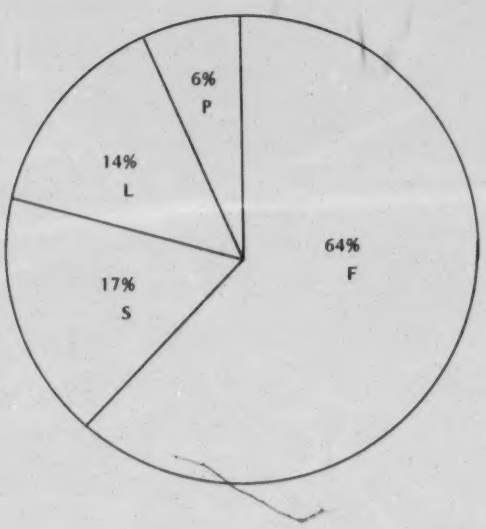

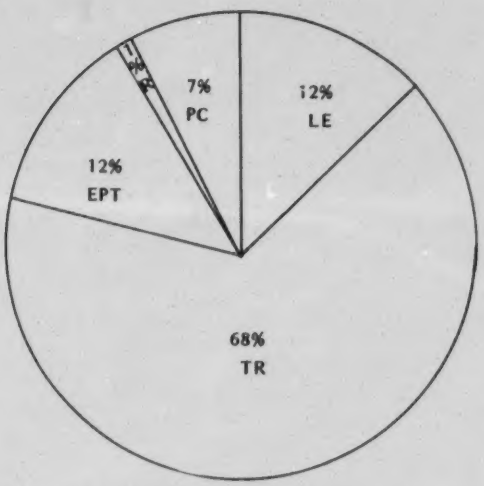

Cities: 50-100,000
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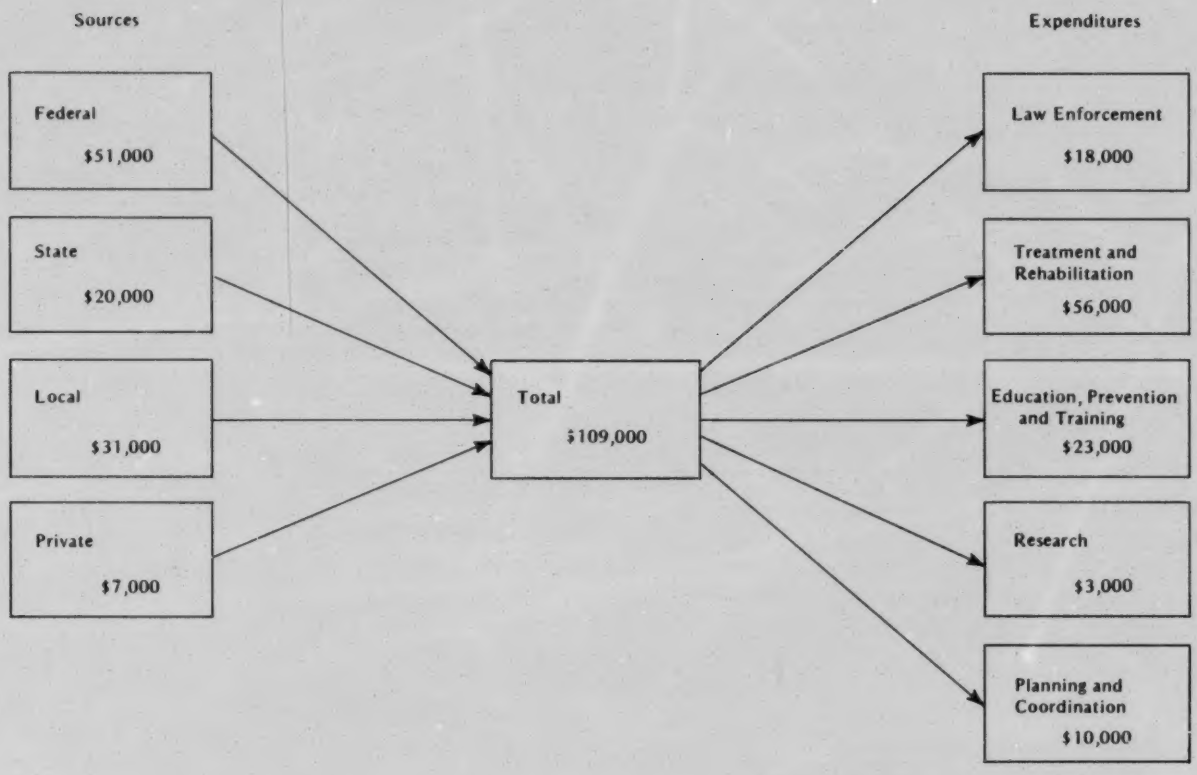
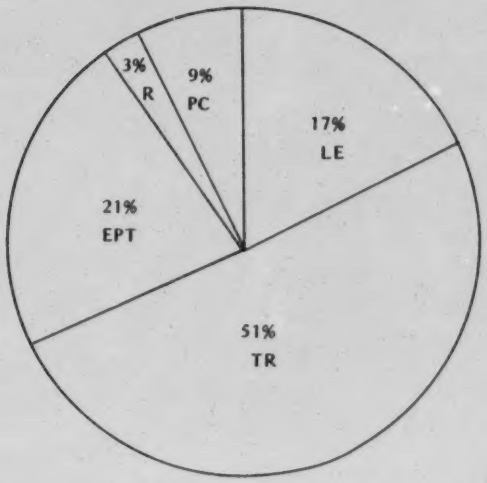
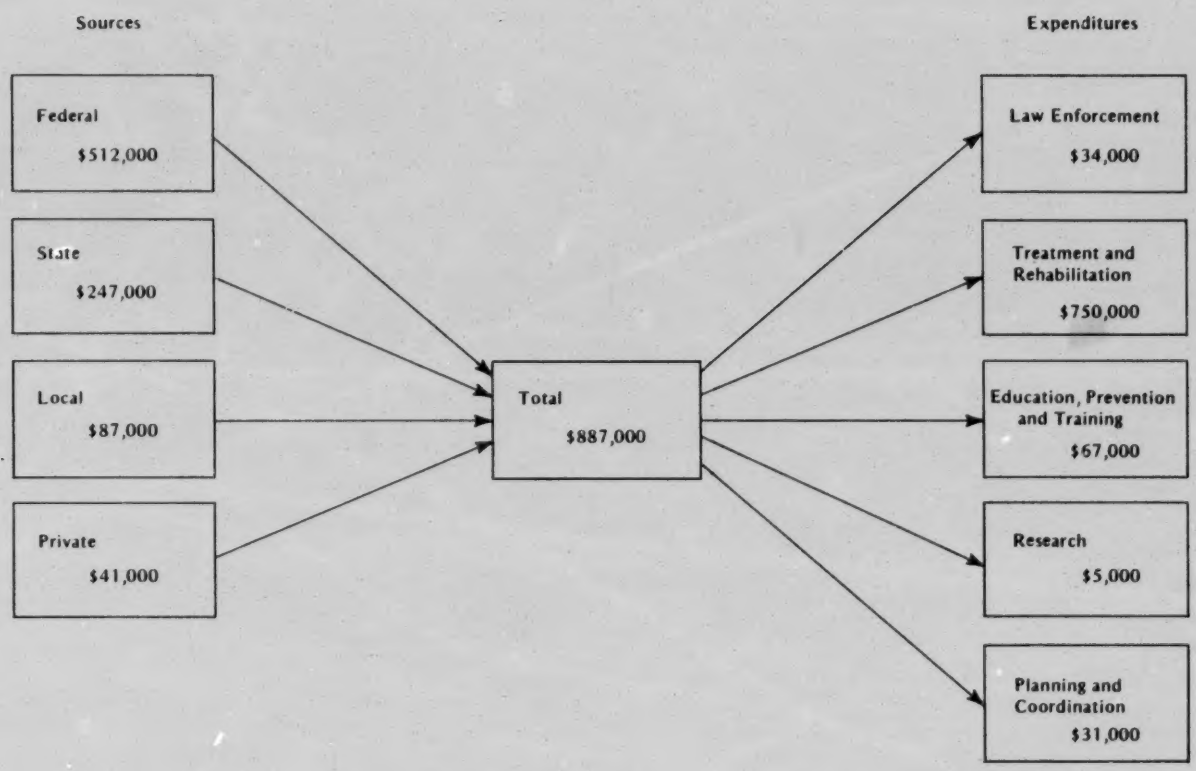


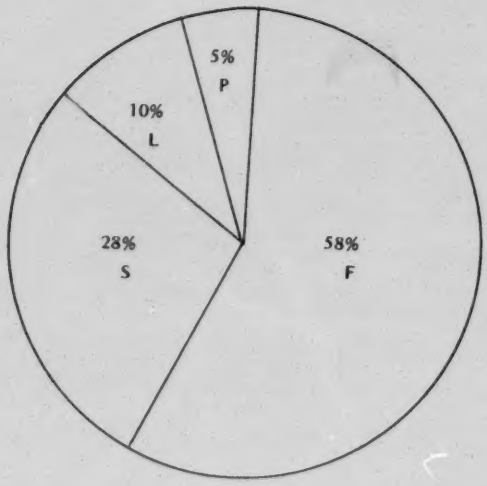


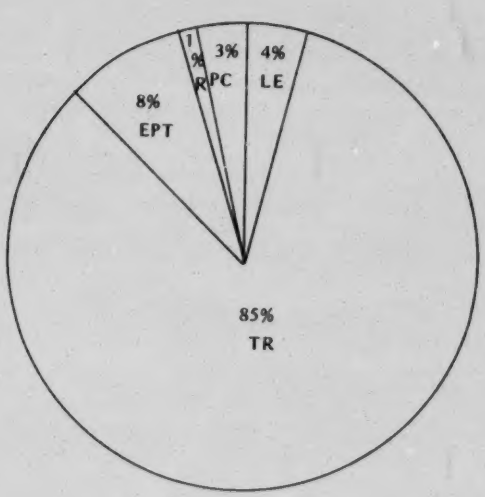
f

Cities: Northeast

N = 23







g
Cities: North Central
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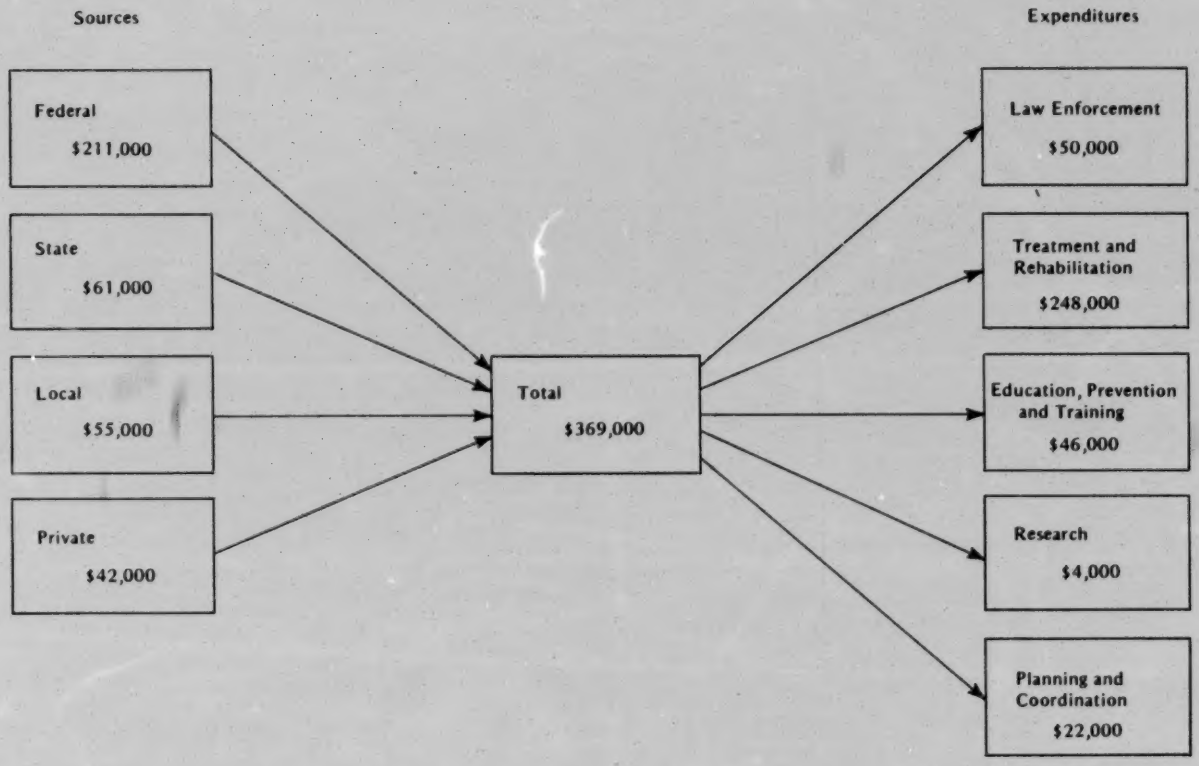

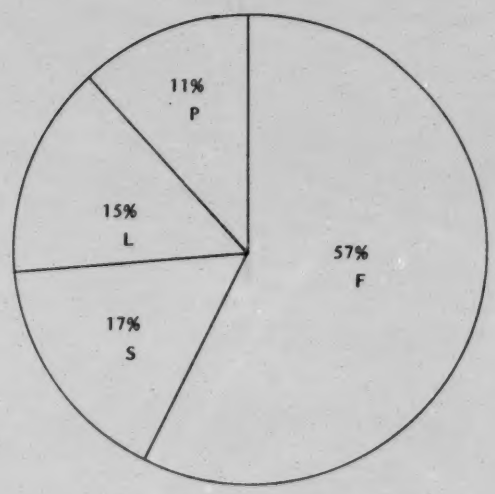

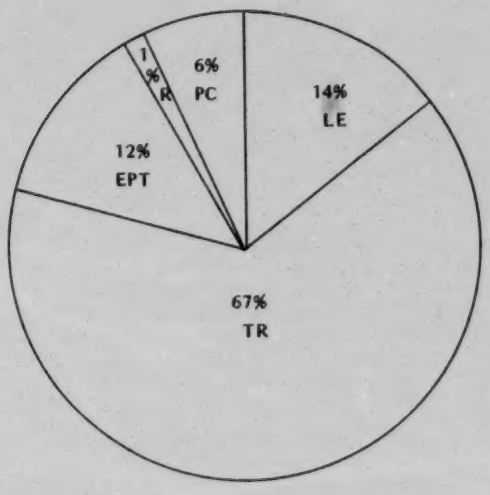

h
Cities: South
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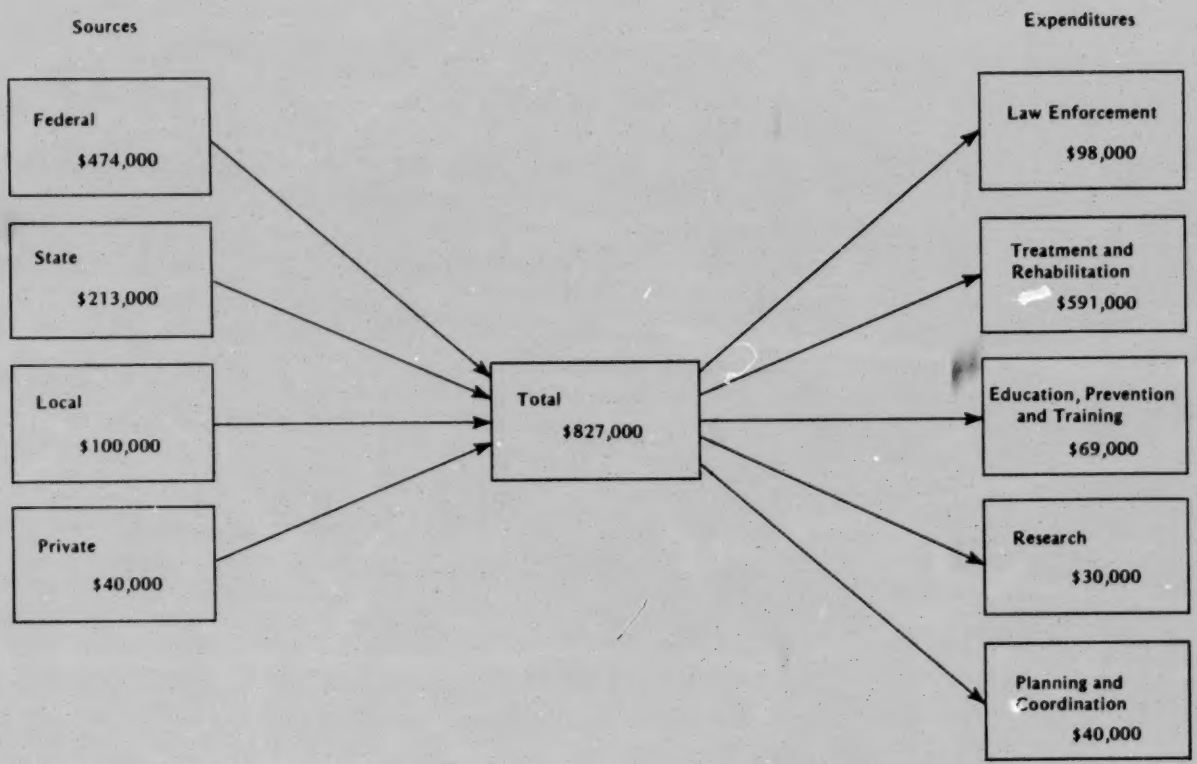
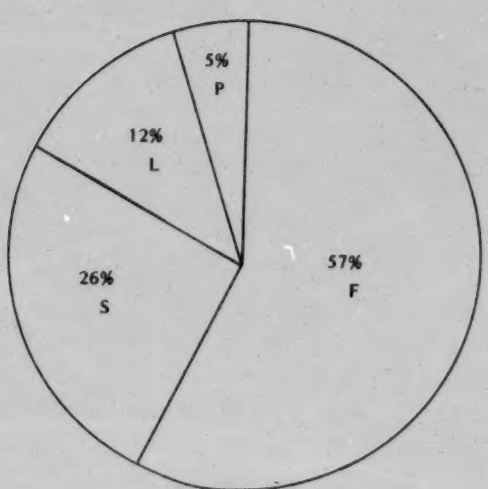
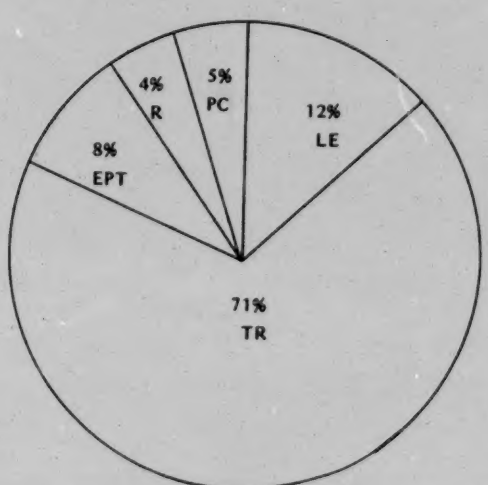
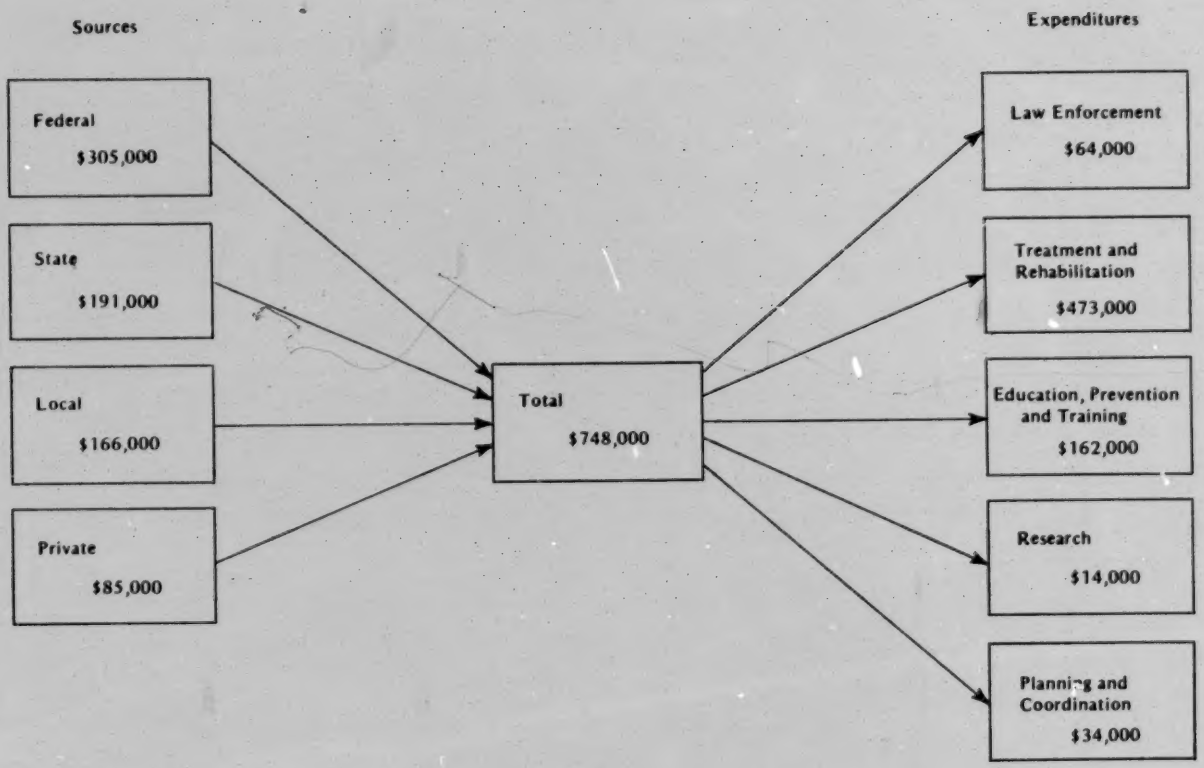
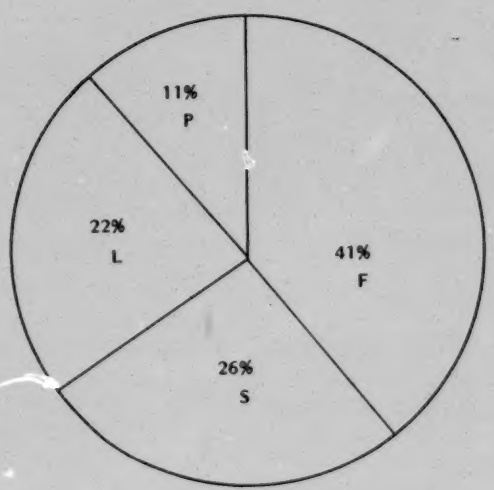


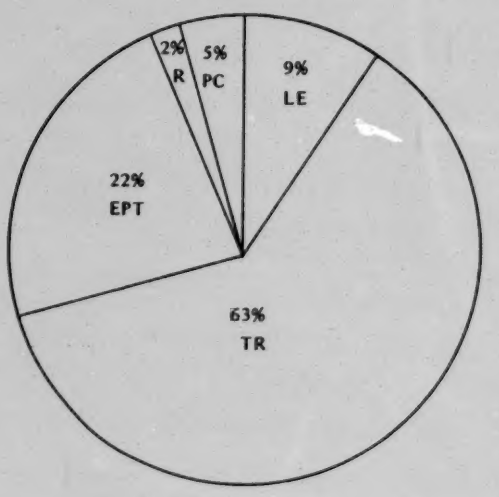




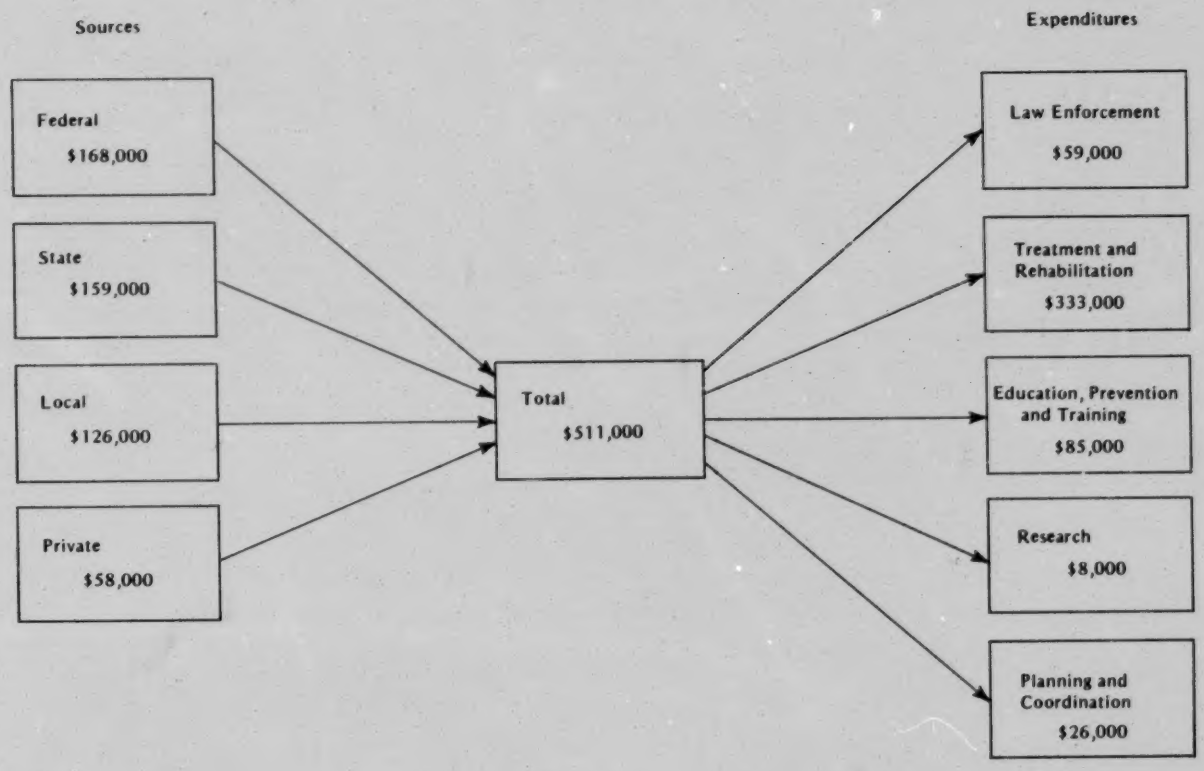
Cities: West
N = 25

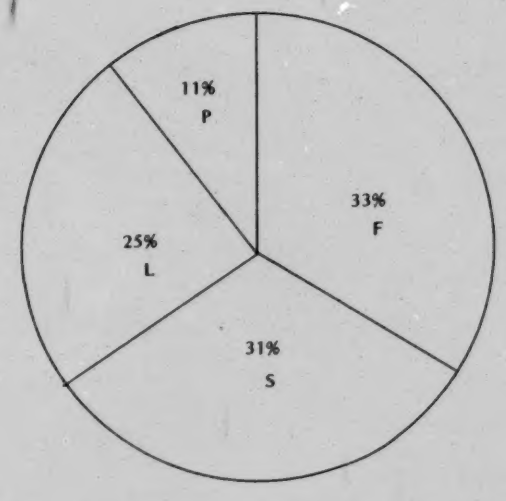


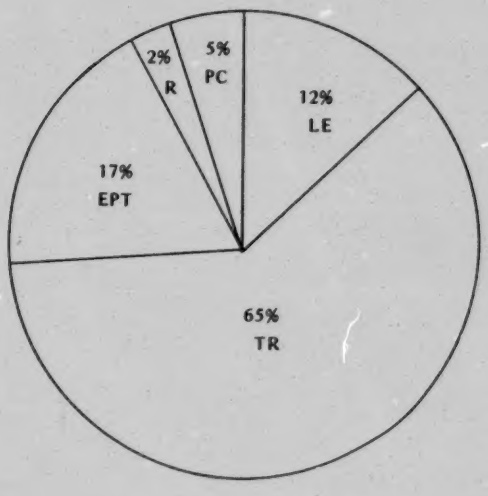




All Counties
N = 85



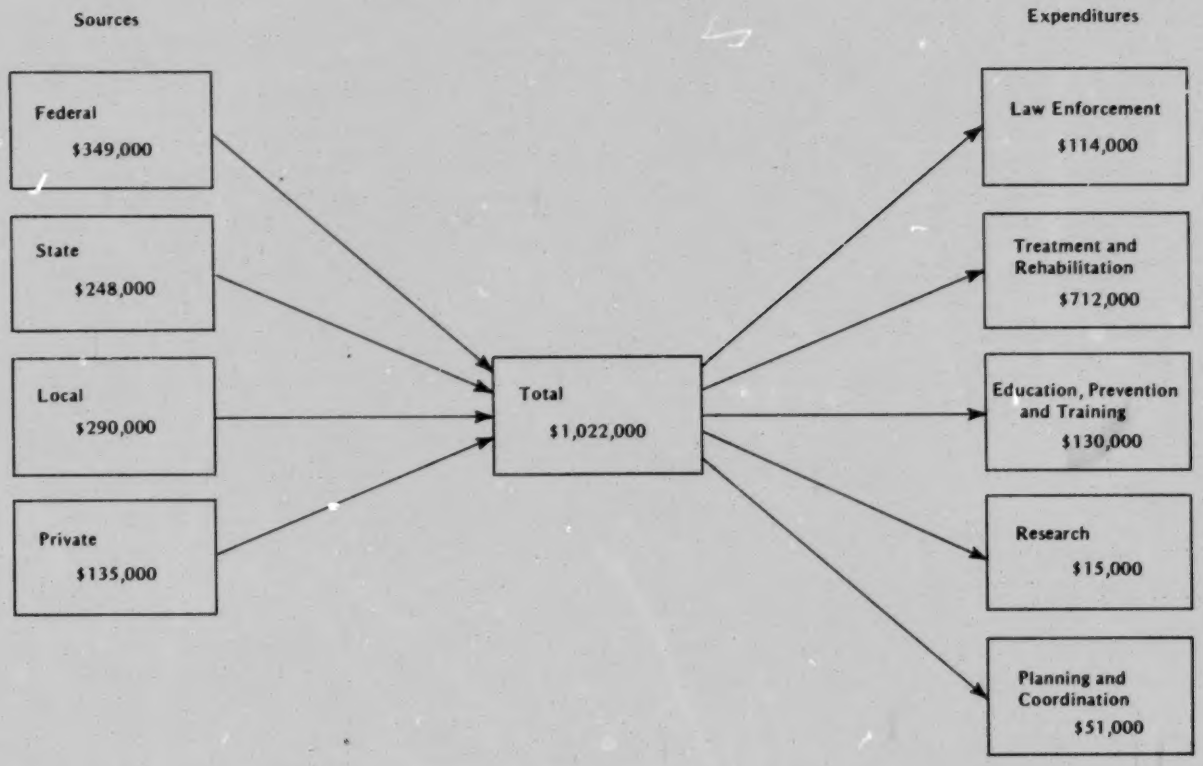


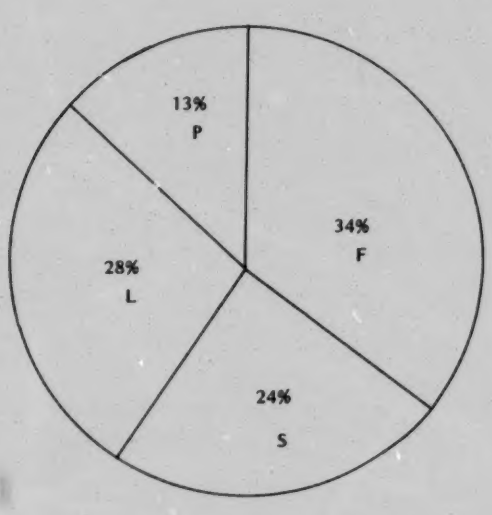


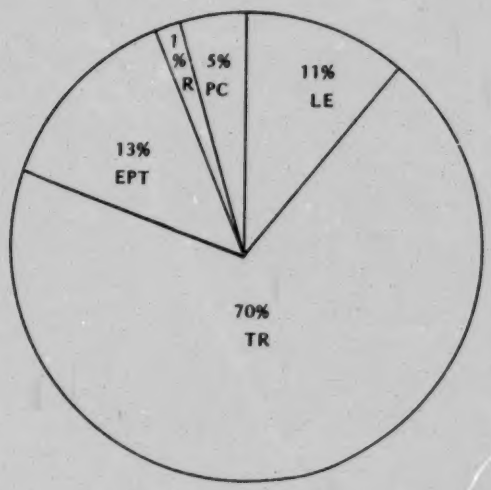
k

Counties. over 500,000

N = 26



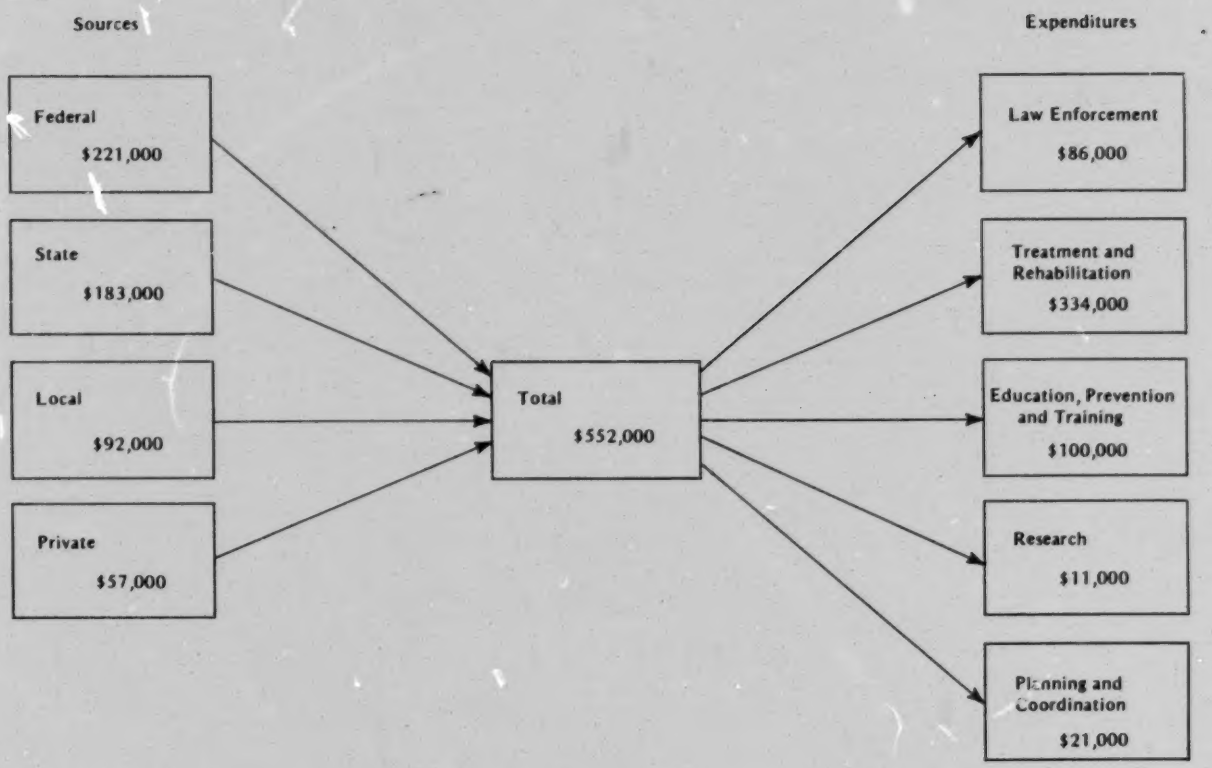


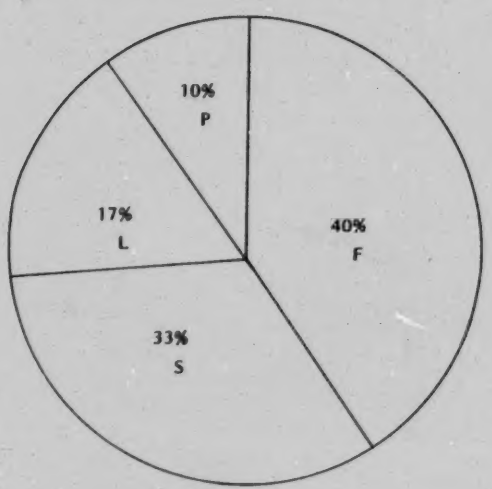


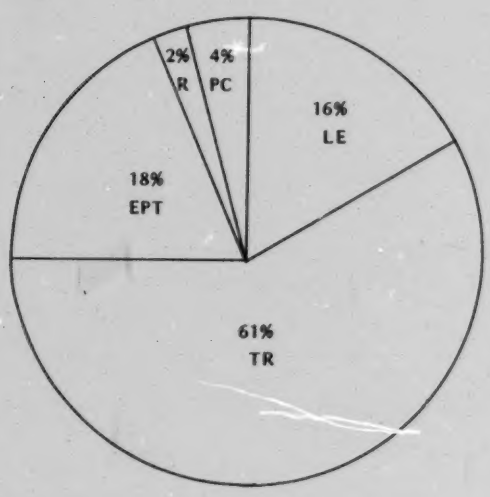
I

Counties: 250-500,000

N = 17







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Counties: 100-250,000

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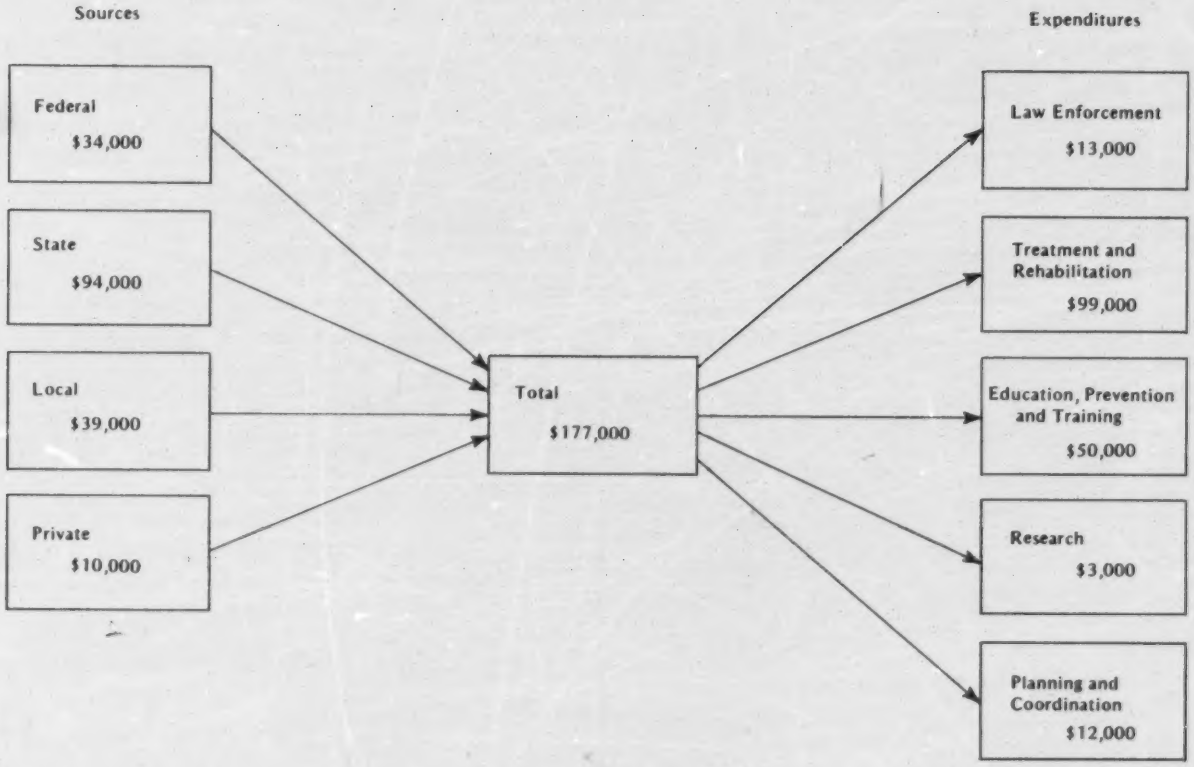
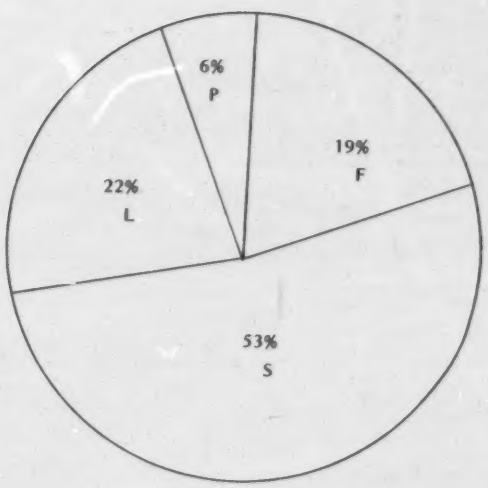
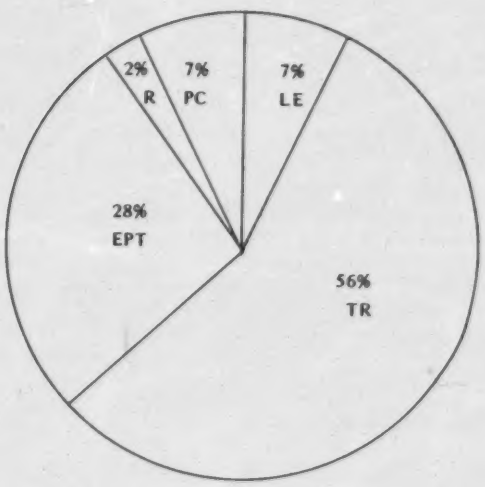


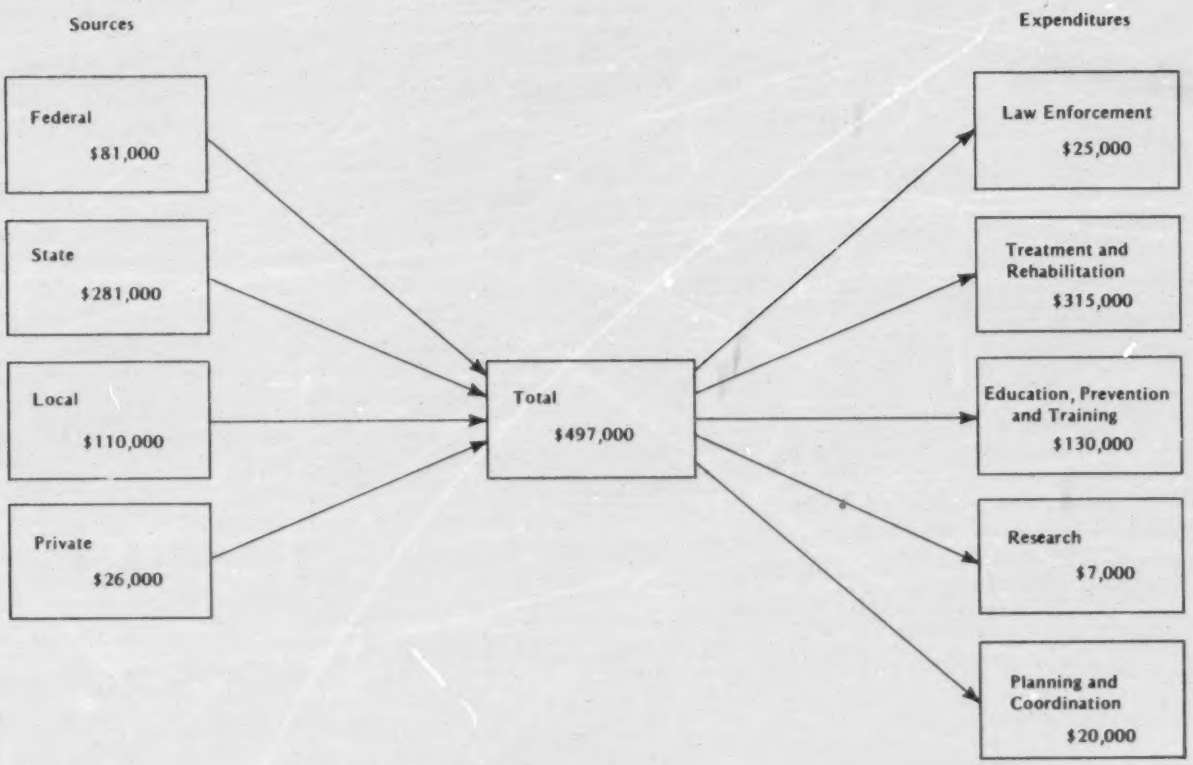


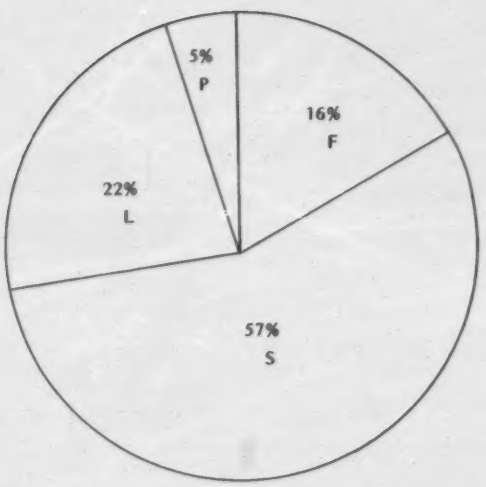


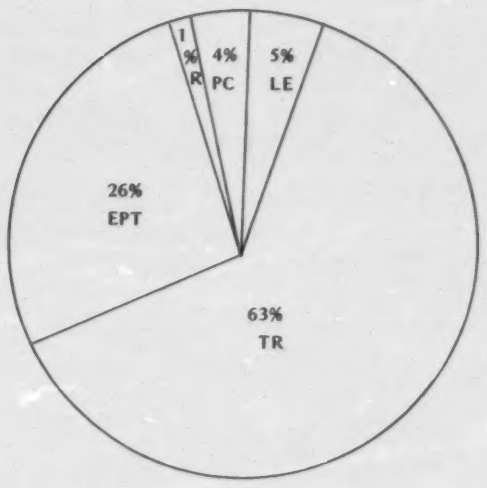
n

Counties: Northeast

N = 29





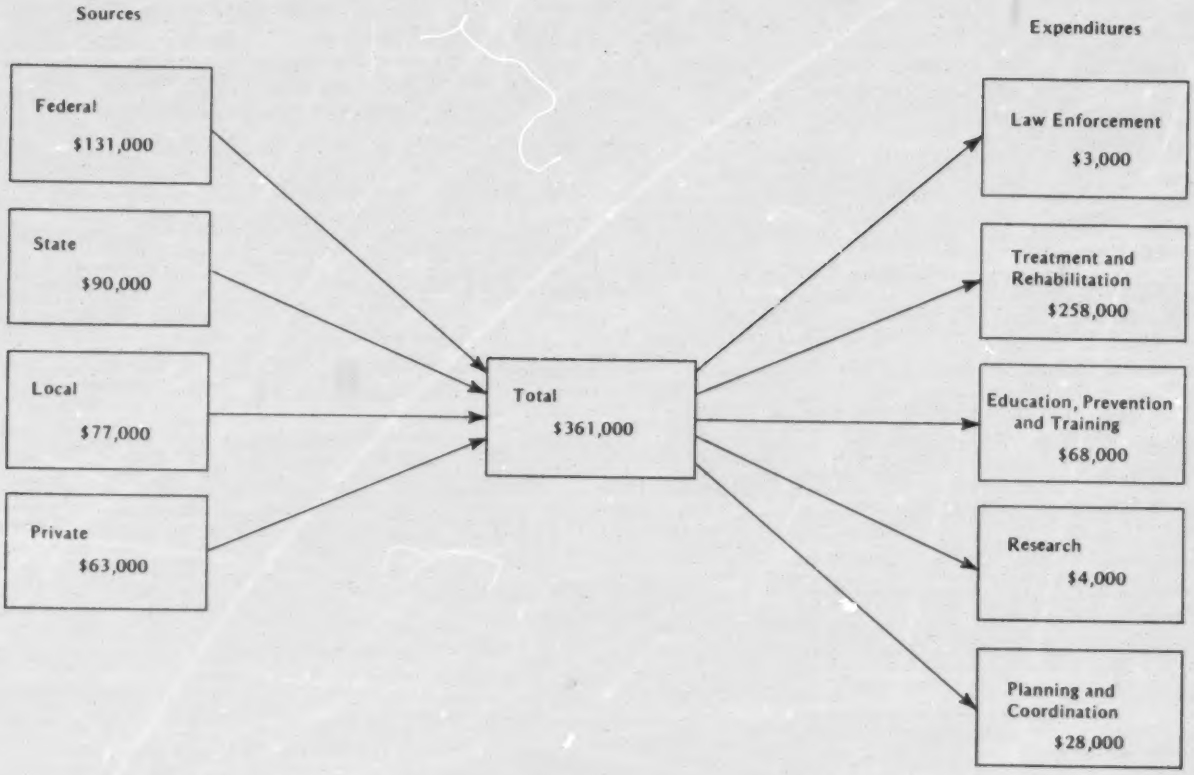


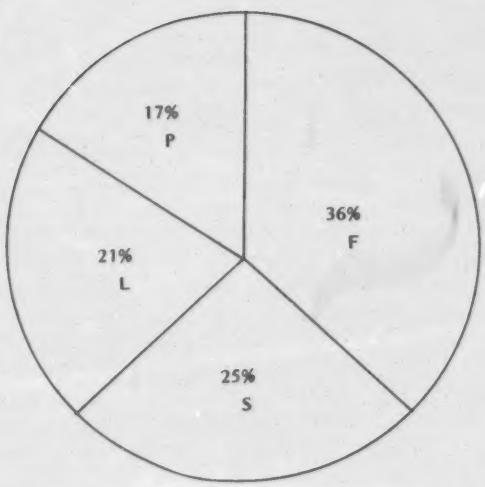
The Drug Abuse Council

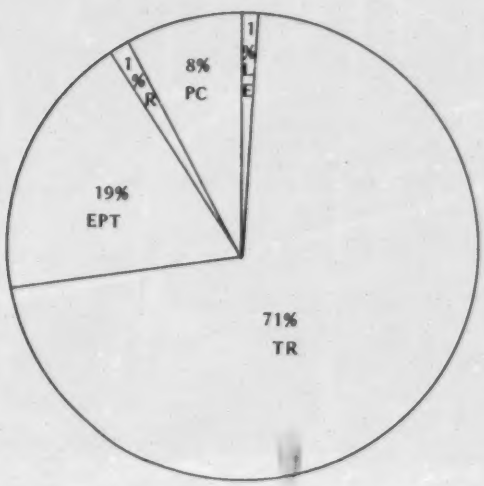
o

Counties: North Central

N = 17







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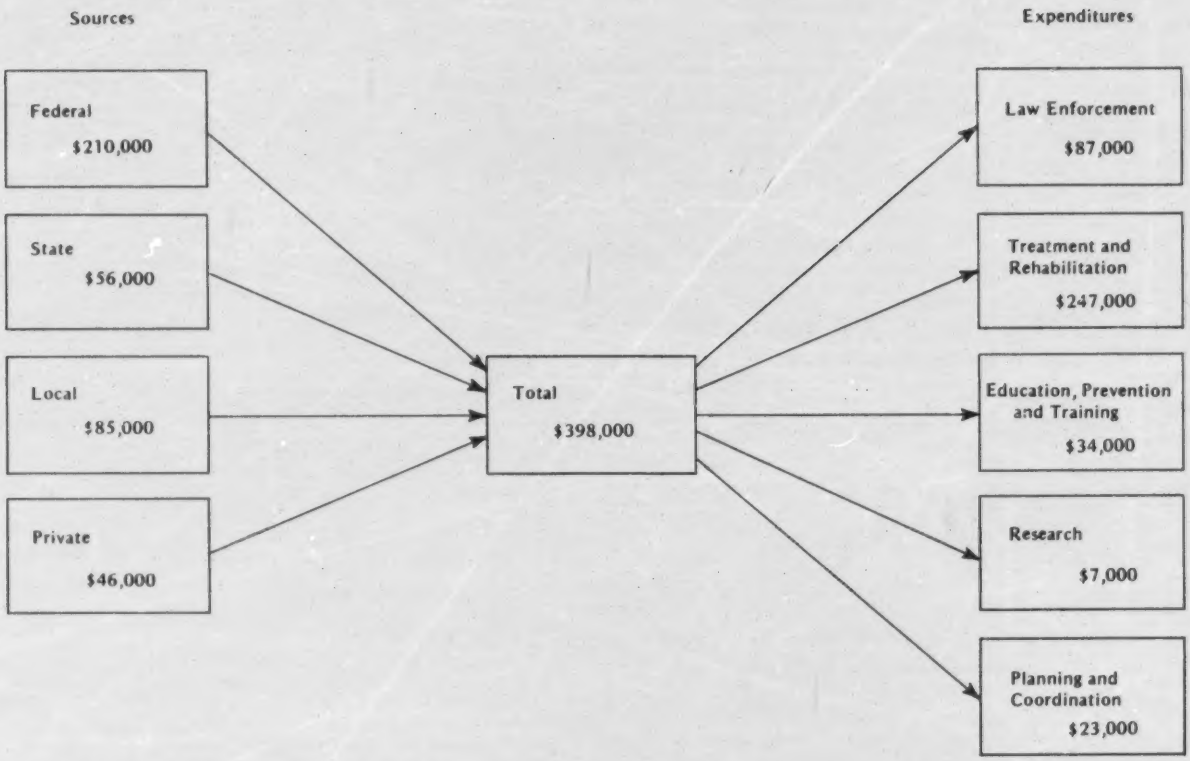
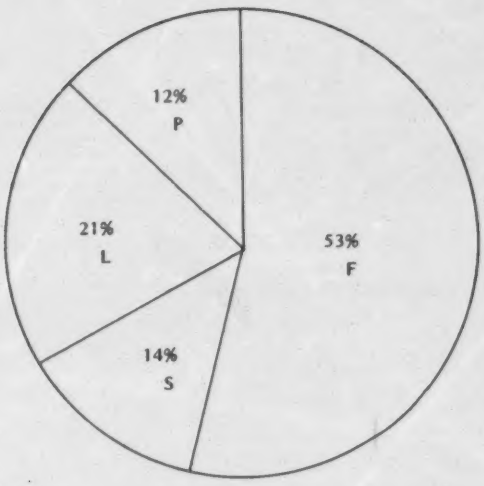
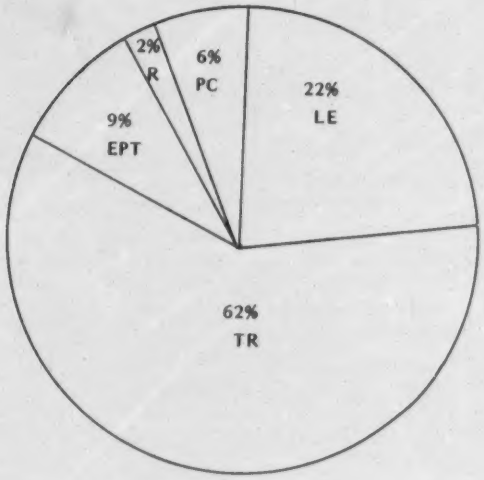
Counties: South

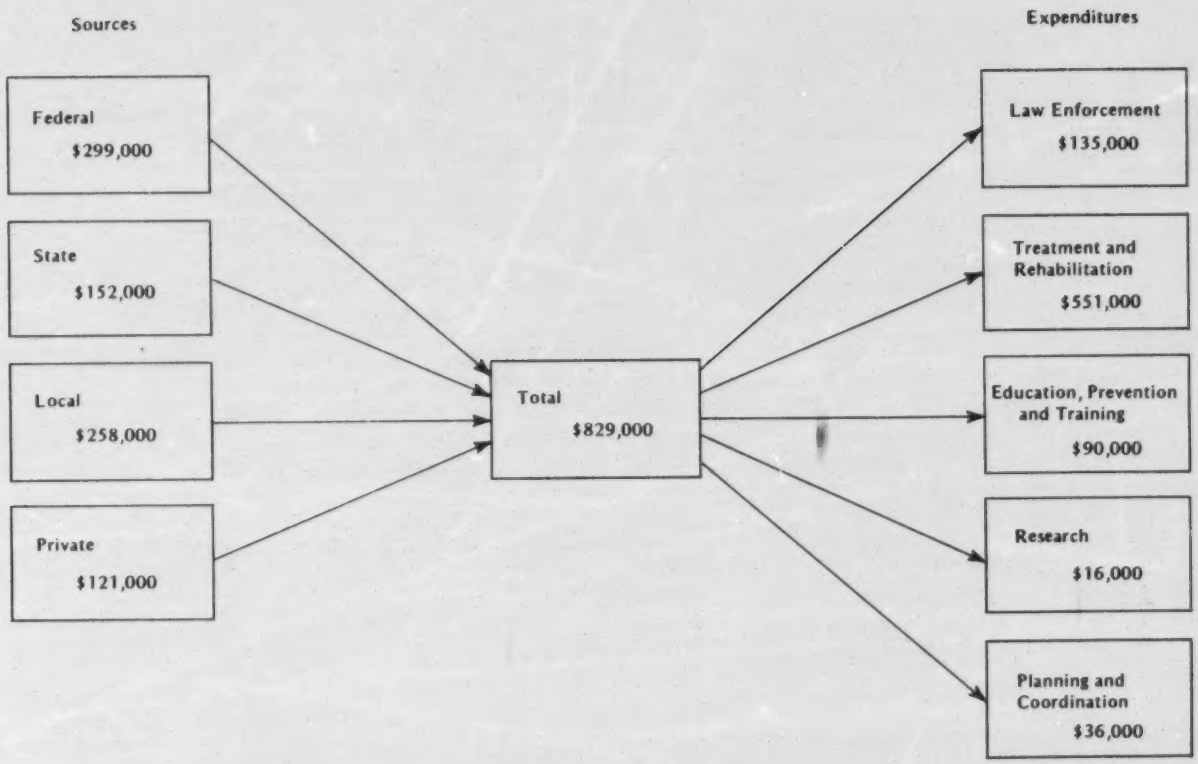
N = 22

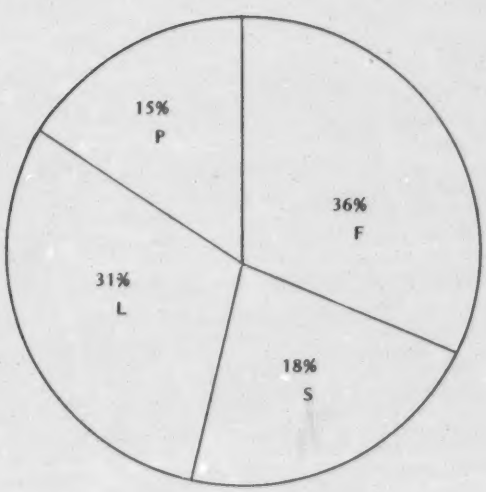


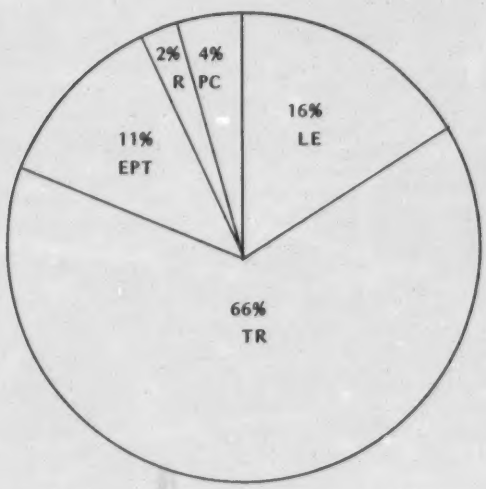




q
Counties: West
N = 17







NATIONAL PROJECTIONS

Although the budgetary figures were only estimates, the number of respondents was considered sufficiently representative to permit national projections. All projections tend to be inaccurate; no pretense is made to the validity of the following figures. However, because so little information in this area has been reported, it is hoped that these projections will be useful in policy analysis and planning. Beyond the problems of projections in general, these projections may not have included certain types of expenditures (for example, federally funded Veteran's Administration drug abuse rehabilitation centers in cities, research projects).

Two methods were used for the projection of the total drug abuse budget: one based on population similarity, one on regional similarity. The first assumes that the responding jurisdictions of a given population size were representative of all jurisdictions of that size. The second assumes that the responding jurisdictions within a given region were representative of all jurisdictions of that region. This section on projections contains three series of charts and tables:

- *Series I—Charts A through D* presents the source and expenditure projections for cities and counties using both methods of projection.
- *Series II—Charts E through M* describes the relative financial breakdown of each source (federal, state, local and private) and expenditure (law enforcement, treatment and rehabilitation, education prevention and training, research, and planning and coordination) by population and by region.
- *Series III—Tables N through Q* represents a compilation of all the budget data, actual and projected, in tabular form.

Series I

As might be expected, the two methods of projection used (by population and region) produced different total numbers of dollars, primarily due to the different response rates of the localities by size and regional breakdowns. Because the average dollars spent was most strongly dependent upon the population size of the jurisdiction, the projection based on population categories is considered to yield a more realistic result. Whichever combination of city and county projections is used, the indicated total dollars expended to control drug abuse is less than one-half billion annually.

Despite the numerical differences in projected dollars arrived at through the two methods of projection (28% for the cities and 15% for the counties), the relative distribution of the sources and expenditures remained consistent. As anticipated, the relative distribution based on the projected figures is comparable to that of the figures from the reporting jurisdictions. Cities were found to depend more heavily than counties upon federal funds for drug abuse: just over one-half of city drug abuse funds were supplied by the federal government; for the counties the figure was one-third. State funds were found to constitute a larger percentage of county than of city drug abuse budgets. Proportionally, federal dollars to state dollars in the cities was 2:1; in the counties it was almost 1:1.

Treatment and rehabilitation efforts were consistently allocated the largest share of the drug abuse budgets. As with the known actual expenditures, the projected figures repeat a nearly identical proportional relationship between the drug abuse education and law enforcement budgets. Again, in the projections, planning and coordination and research never exceed 10% of the total drug abuse budget.

Series II

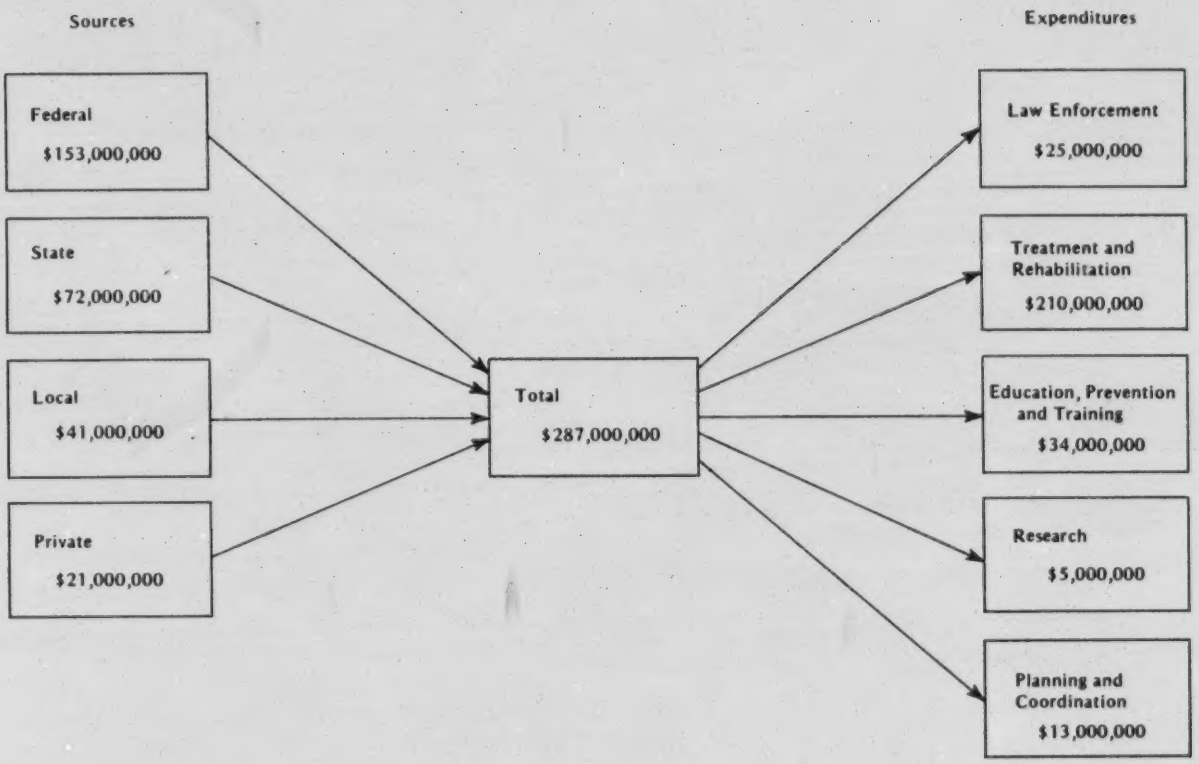
Charts E through M are useful for showing breakdowns within specific categories of sources and expenditures. Some of the more interesting findings derived from this series include:

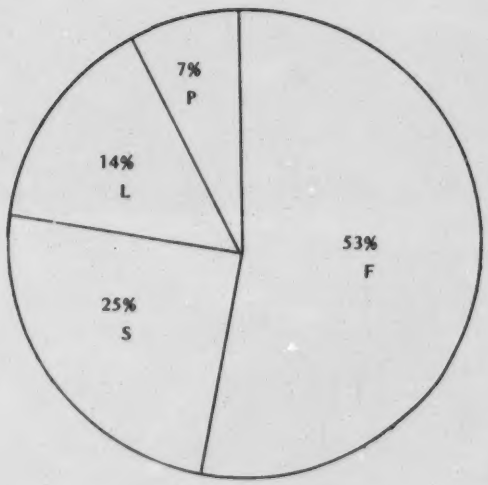
- Three times as many federal drug abuse dollars were spent in the cities than the counties.
- Of the federal drug abuse dollars spent in the cities, 39% was received by the 26 largest cities.
- Of the federal dollars received by counties, 48% was received by the 58 largest counties.
- The cities in the North Central region received the smallest proportion of federal drug abuse funding.
- State dollars were more equally distributed between the cities and counties than federal dollars.
- Of the state funds received by the cities, nearly one-half were received by the 26 largest cities.
- The Northeast states were the largest contributors of drug abuse funds, while the North Central states were the smallest.
- The counties were spending about the same amount of local money on drug abuse as the cities.
- Both the West cities and counties were contributing the largest percentage of the local funds.
- Drug abuse law enforcement expenditures were heavily concentrated in the South and West.
- Of the research funds received by the cities, the 30 cities with populations between 250,000-500,000 reported over one-half of that money was spent within their jurisdictions.

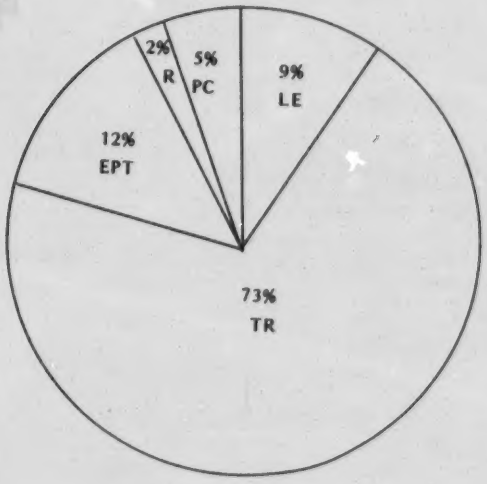
Series III

The third series (Tables N-Q) includes the basic figures from which all the preceding tables were derived.

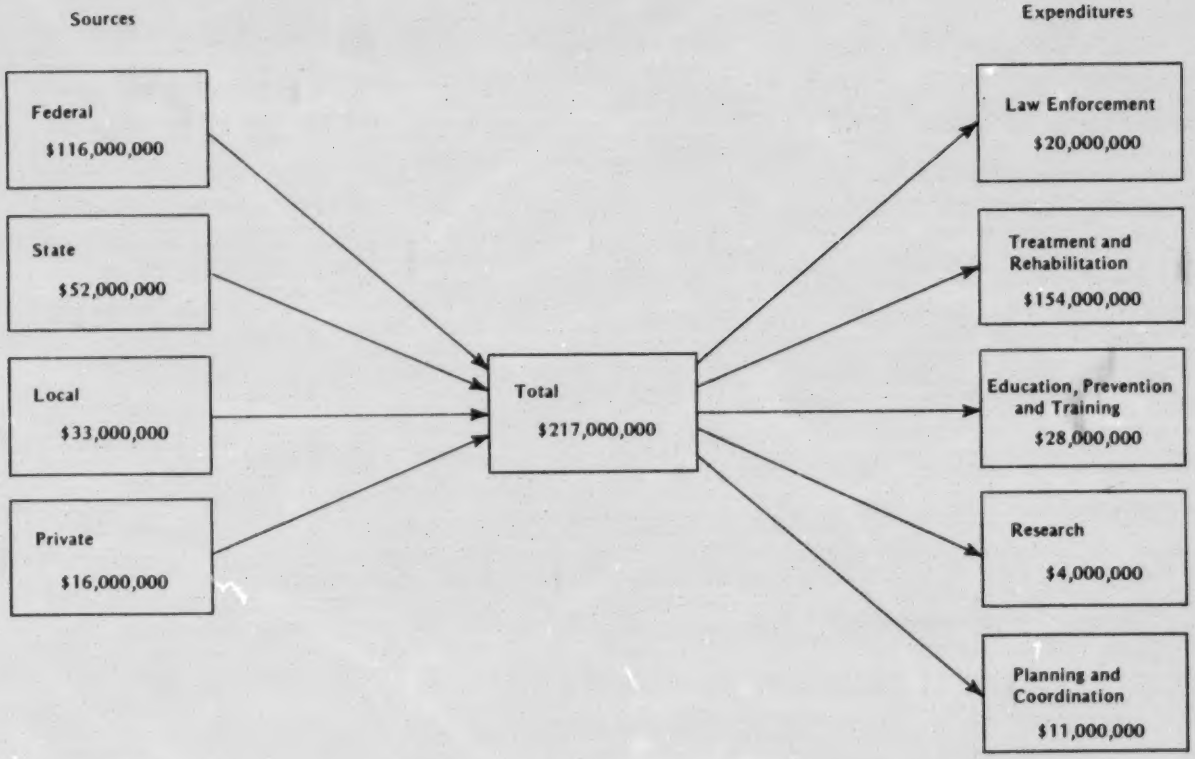
A
Projection for All Cities
Based on Region

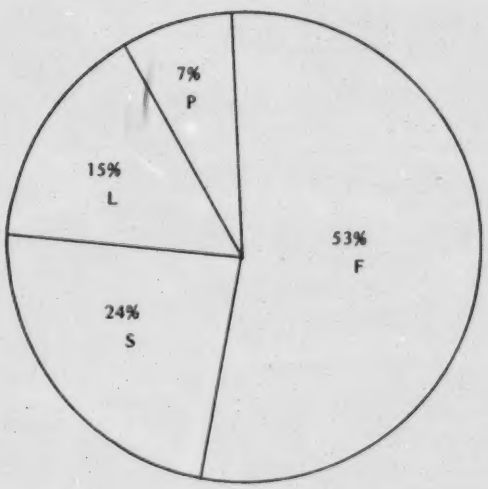


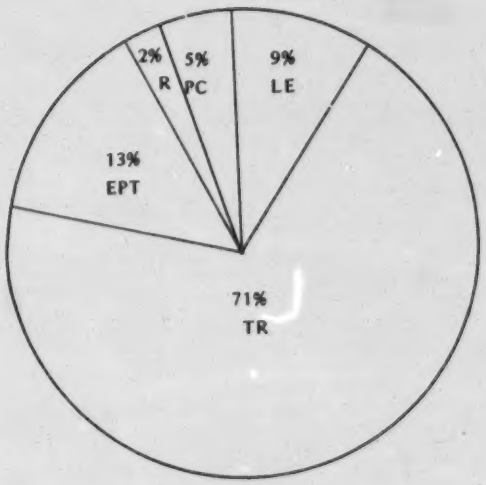




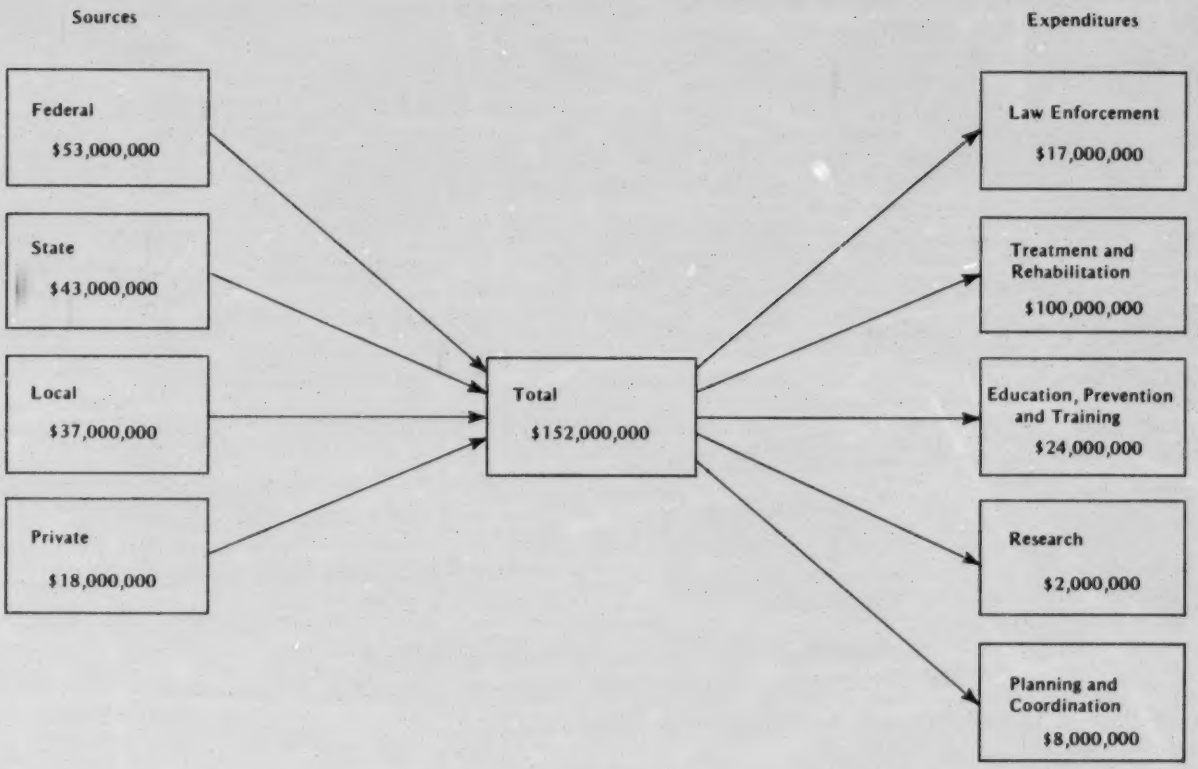
B
Projection for All Cities
Based on Population

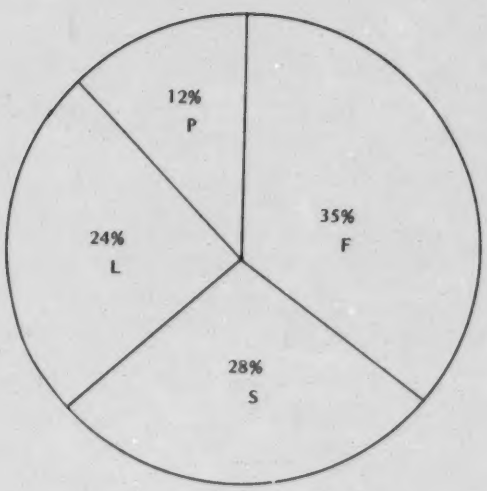


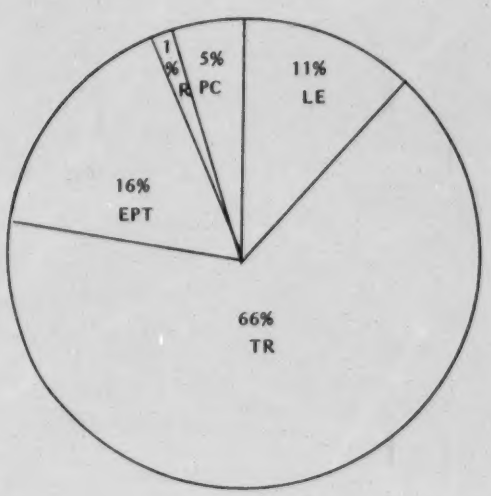




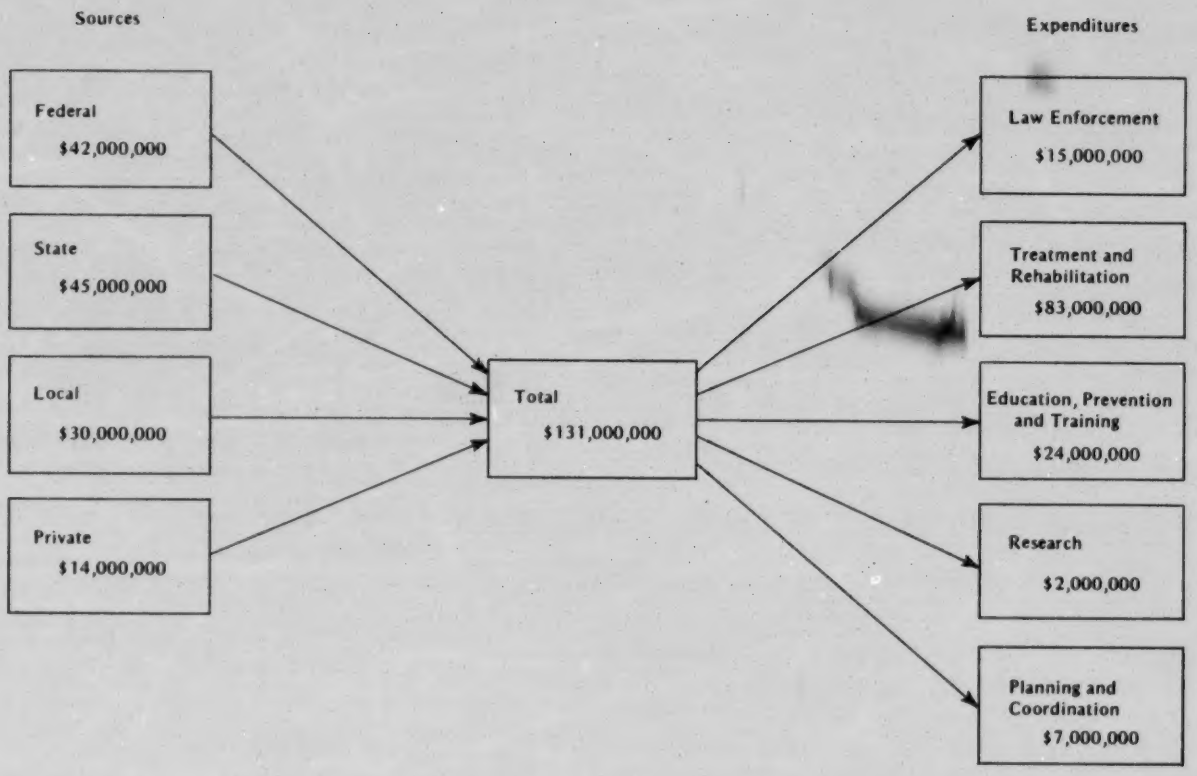
C
Projection for All Counties
Based on Region

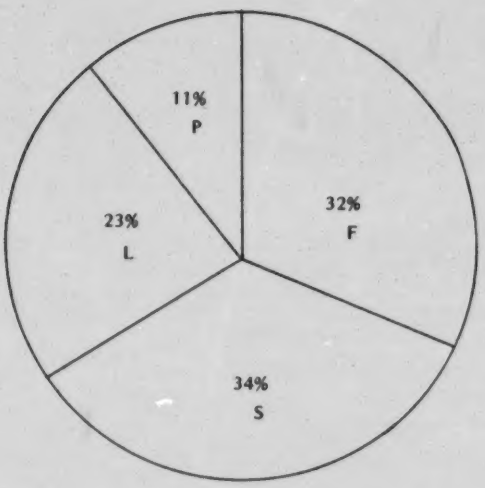


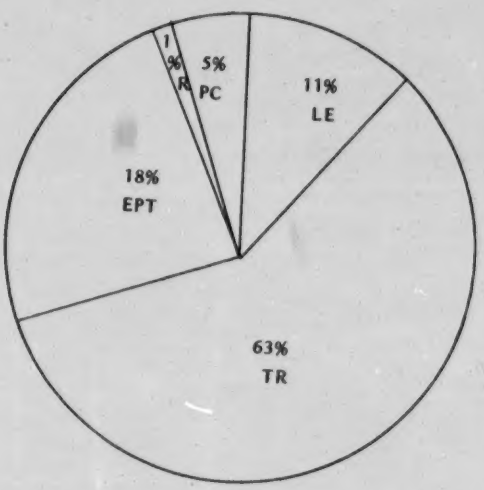




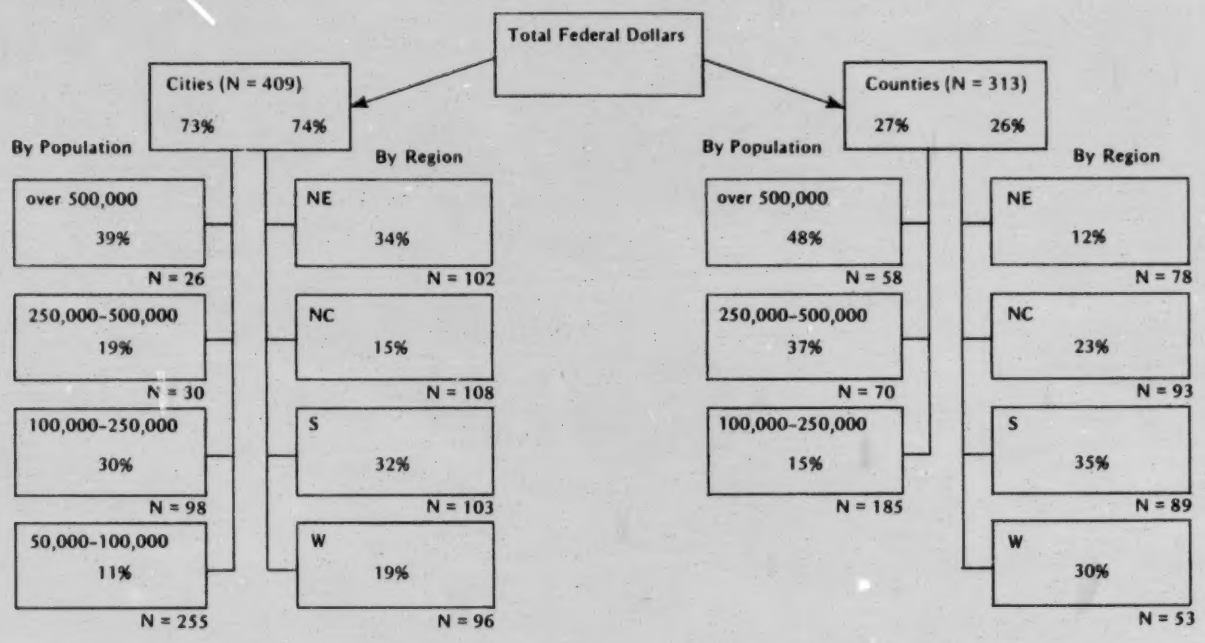
D
Projection for All Counties
Based on Population



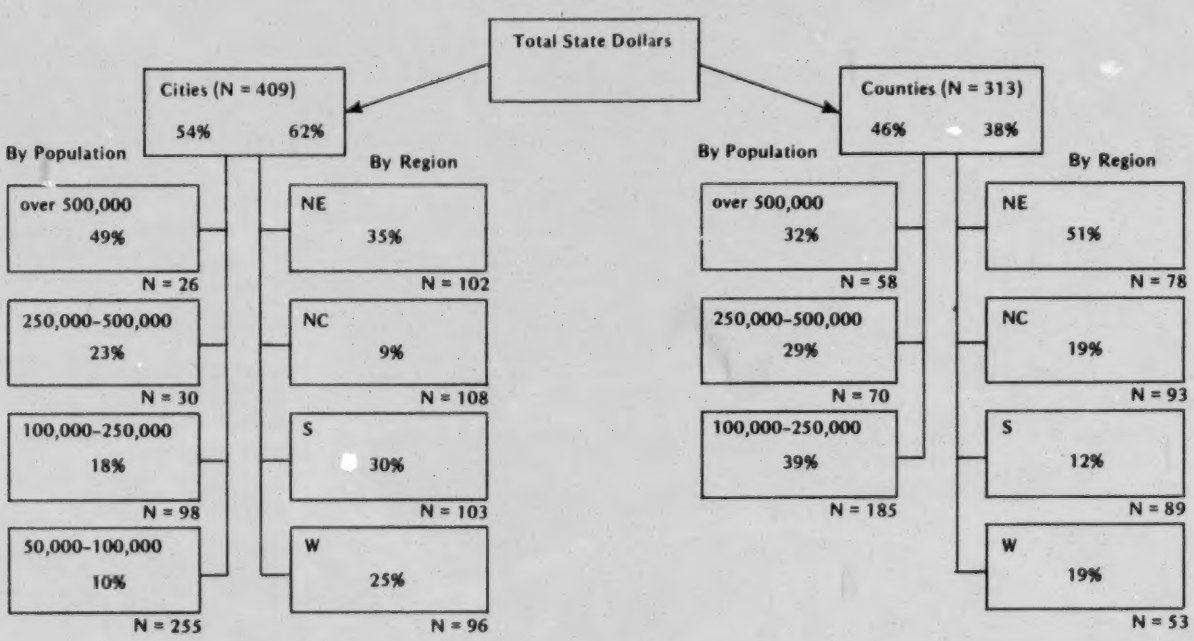




E
Projected Allocation of Federal Dollars

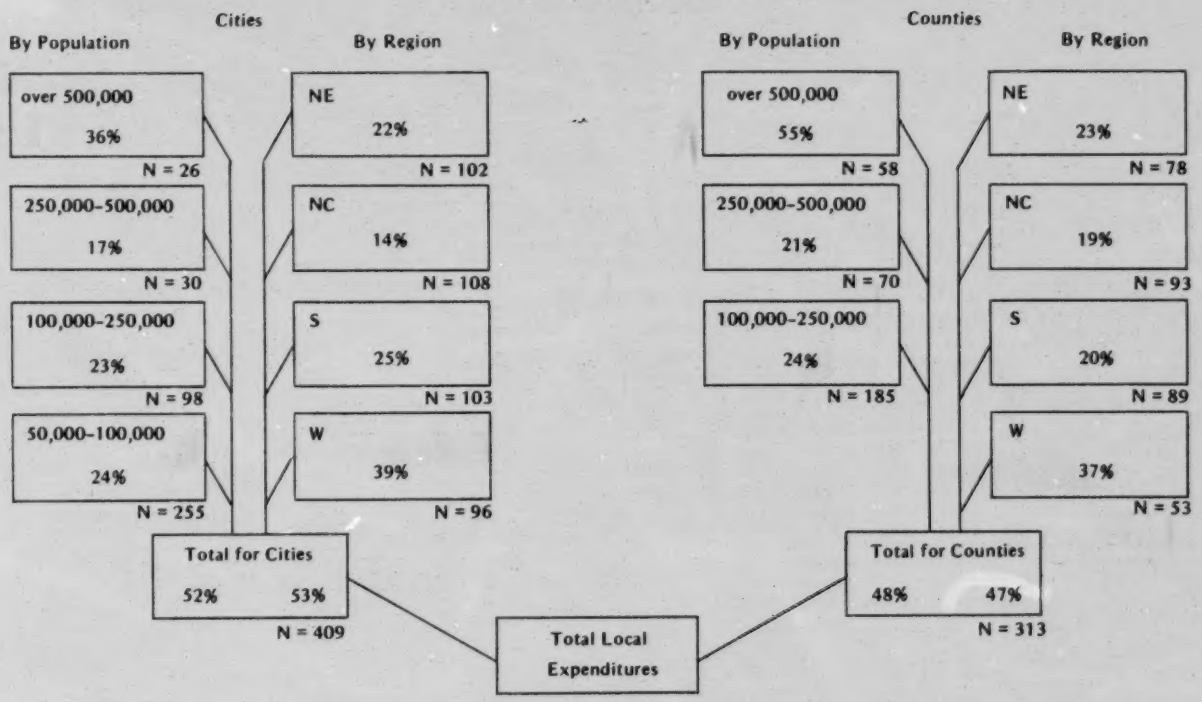


F
Projected Allocation of State Dollars



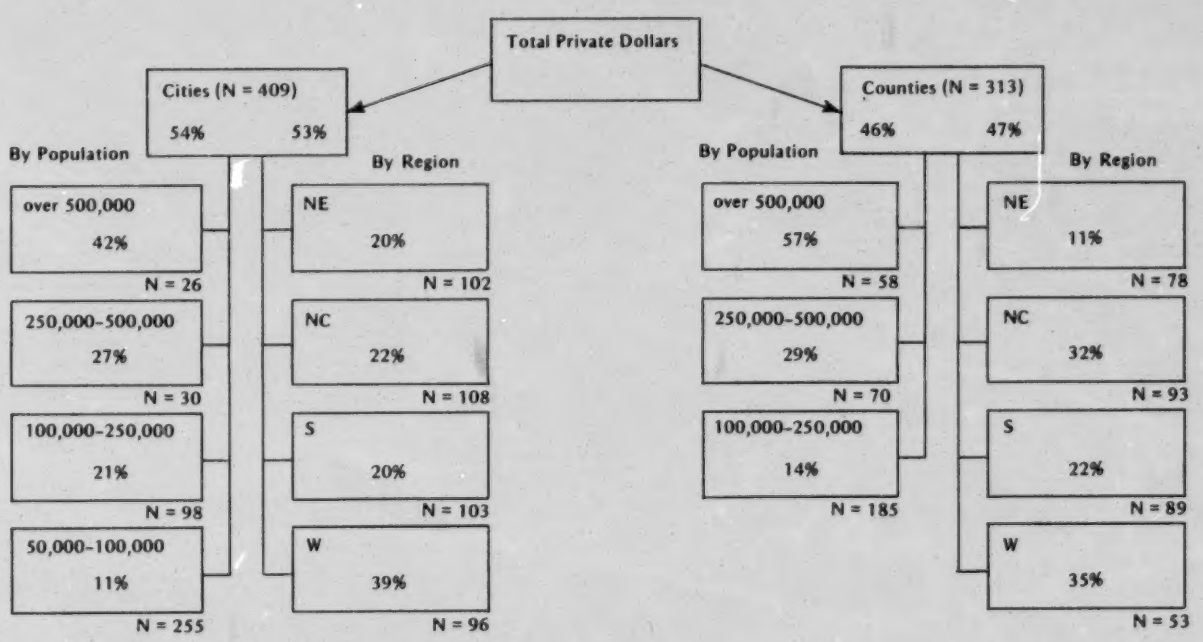
G

Projected Local Dollars Allocated



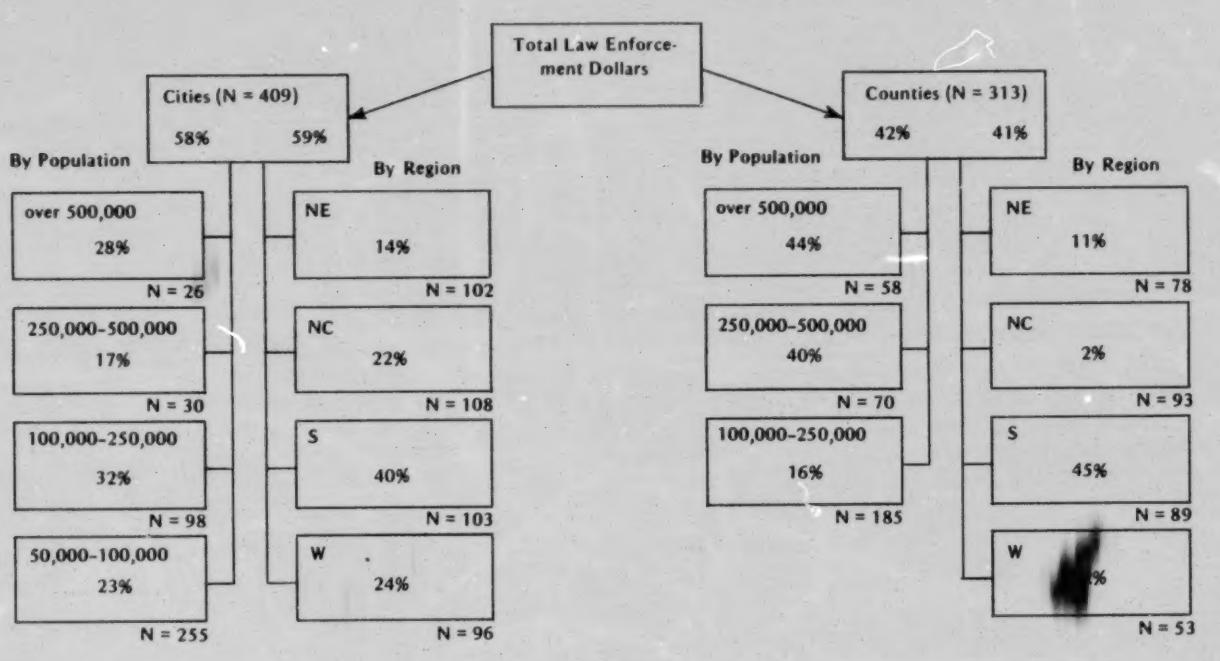
H

Projected Allocation of Private Dollars



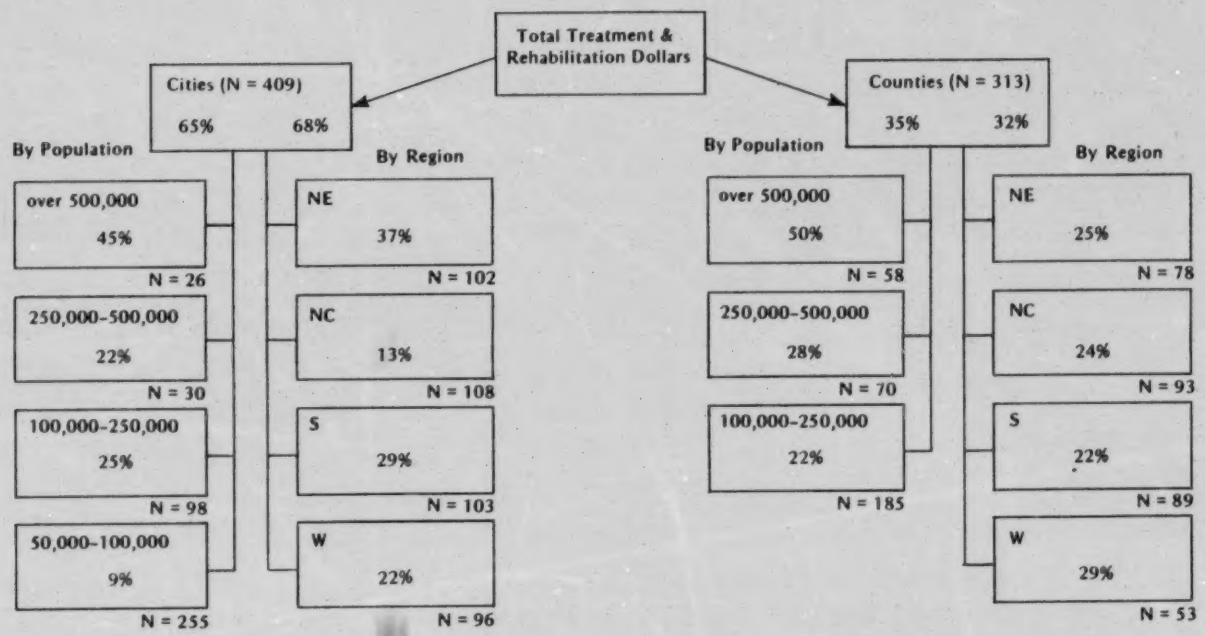
I

Projected Allocation of Law Enforcement Expenditures



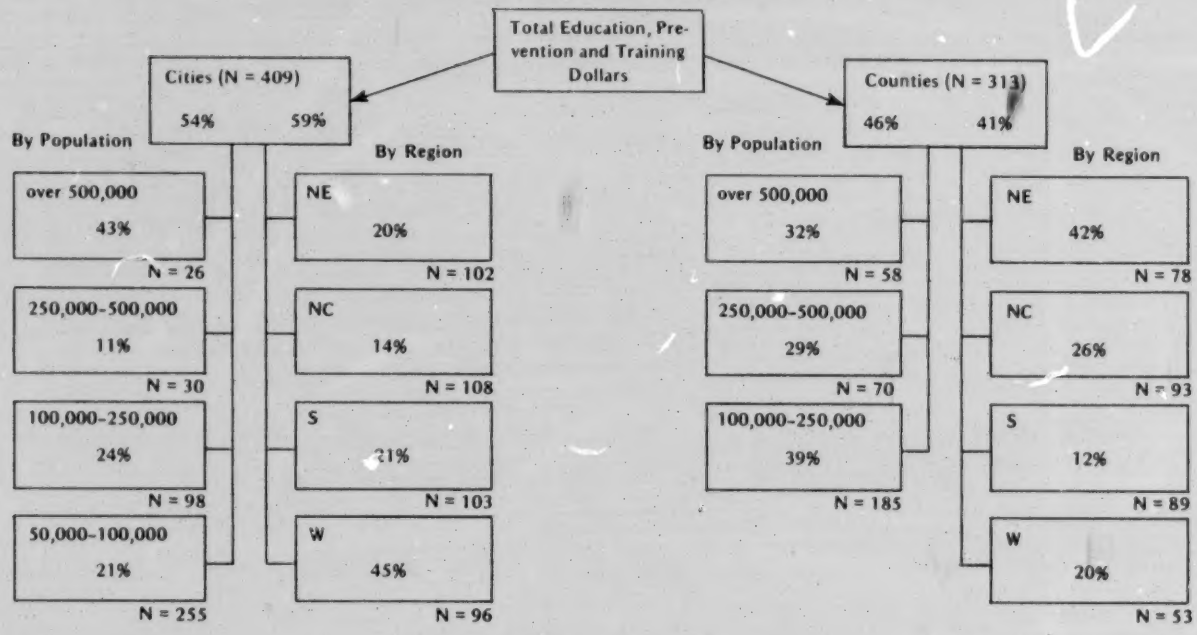
J

Projected Allocation of Treatment and Rehabilitation Expenditures



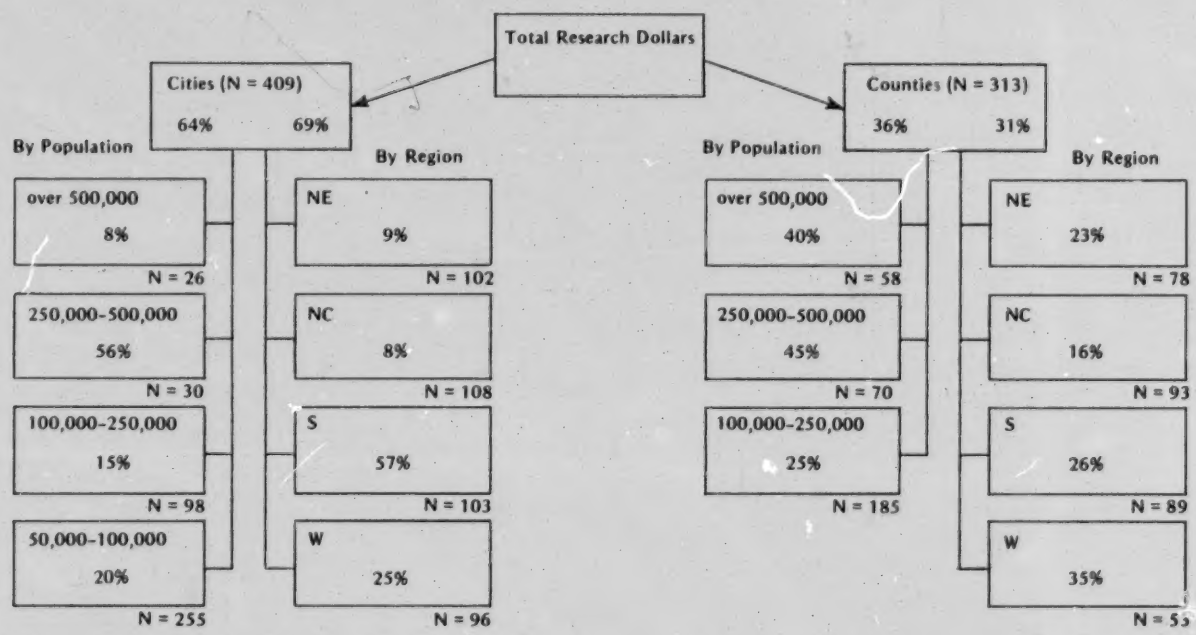
K

Projected Allocation of Education, Prevention and Training Expenditures



L

Projected Allocation of Research Expenditures



M

Projected Allocation of Planning and Coordination Expenditures

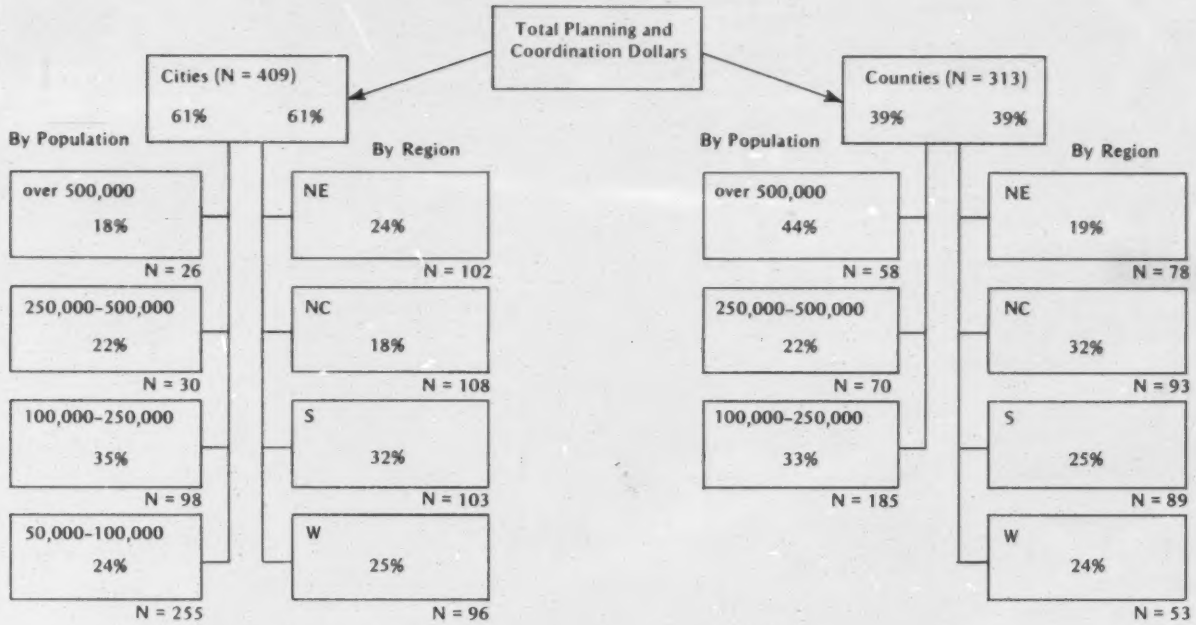


Table N

Known & Projected Dollars Received by Cities (in thousands)

	Total Cities	Responding Cities	Local Average $	Local Total $	State Average $	State Total $	Federal Average $	Federal Total $	Private Average $	Private Total $	Projected Total $
Total	409	97	101	41,309	173	70,757	366	149,694	52	21,268	283,028
Population											
>500	26	9	458	11,908	980	25,480	1,727	44,902	252	6,552	88,842
250-500	30	12	187	5,610	399	11,970	750	22,500	140	4,200	44,280
100-250	98	23	79	7,742	94	9,212	360	35,280	33	3,234	55,468
50-100	255	53	31	7,905	20	5,100	51	13,005	7	1,785	27,795
Total				33,165		51,762		115,687		15,771	216,385
Region											
NE	102	23	87	8,874	247	25,194	512	52,224	41	4,182	90,474
NC	108	27	55	5,940	61	6,588	211	22,788	42	4,536	39,852
S	103	22	100	10,300	213	21,939	474	48,822	40	4,120	85,181
W	96	25	166	15,936	191	18,336	305	29,280	85	8,160	71,712
Total				41,050		72,057		153,114		20,998	287,219
% Difference				21%		33%		28%		28%	28%

Table O

Known & Projected Dollars Received by Counties (in thousands)

	Total Counties	Responding Counties	Local Average $	Local Total $	State Average $	State Total $	Federal Average $	Federal Total $	Private Average $	Private Total $	Projected Total $
Total	313	85	126	39,438	159	49,767	168	52,584	58	18,154	159,943
Population											
>500	58	26	290	16,820	248	14,384	349	20,242	135	7,830	59,276
250-500	70	17	92	6,440	183	12,810	221	15,470	57	3,990	38,710
100-250	185	42	39	7,215	94	17,390	34	6,290	10	1,850	32,745
50-100	–	–	–	–	–	–	–	–	–	–	–
Total				30,475		44,584		42,002		13,670	130,731
Region											
NE	78	29	110	8,580	281	21,918	81	6,318	26	2,028	38,844
NC	93	17	77	7,161	90	8,370	131	12,183	63	5,859	33,573
S	89	22	85	7,565	56	4,984	210	18,690	46	4,094	35,333
W	53	17	258	13,674	152	8,056	299	15,847	121	6,413	43,990
Total				36,980		43,328		53,038		18,394	151,740
% Difference				19%		3%		23%		29%	15%

Table P

Known & Projected Expenditures by Cities (in thousands)

	Total Cities	Responding Cities	Law Enforcement Average $	Law Enforcement Total $	Treatment & Rehabilitation Average $	Treatment & Rehabilitation Total $	Education Prevention & Training Average $	Education Prevention & Training Total $	Research Average $	Research Total $	Planning & Coordination Average $	Planning & Coordination Total $	Projected Total $
Total	409	97	61	24,949	503	205,727	86	35,174	13	5317	31	12,679	283,846
Population													
>500	26	9	222	5,772	2,637	68,562	470	12,220	12	312	75	1950	88,816
250-500	30	12	115	3,450	1,104	33,120	106	3,180	72	2160	79	2,370	44,280
100-250	98	23	67	6,566	385	37,730	70	6,860	6	588	38	3,724	55,468
50-100	255	53	18	4,590	56	14,280	23	5,865	3	765	10	2,550	28,050
Total				20,378		153,692		28,125		3,825		10,594	216,614
Region													
NE	102	23	34	3,468	750	76,500	67	6,834	5	510	31	3,162	90,474
NC	108	27	50	5,400	248	26,784	46	4,968	4	432	22	2,376	39,960
S	103	22	98	10,094	591	60,873	69	7,107	30	3,090	40	4,120	85,284
W	96	25	64	6,144	473	45,408	162	15,552	14	1,344	34	3,264	71,712
Total				25,106		209,565		34,461		5,376		12,922	287,430
% Difference				21%		31%		20%		34%		20%	28%

Table Q

Known & Projected Expenditures by Counties (in thousands)

	Total Counties	Responding Counties	Law Enforcement Average $	Law Enforcement Total $	Treatment & Rehabilitation Average $	Treatment & Rehabilitation Total $	Education Prevention & Training Average $	Education Prevention & Training Total $	Research Average $	Research Total $	Planning & Coordination Average $	Planning & Coordination Total $	Projected Total $
Total	313	85	59	18,467	333	104,229	85	26,608	8	2,514	26	8,138	159,956
Population													
>500	58	26	114	6,612	712	41,296	130	7,540	15	870	51	2,958	59,276
250-500	70	17	86	6,020	334	23,380	100	7,000	11	770	21	1,470	38,640
100-250	185	42	13	2,405	99	18,315	50	9,250	3	555	12	2,220	32,745
50-100	–	–	–	–	–	–	–	–	–	–	–	–	–
Total				15,037		82,991		23,790		2,195		6,648	130,661
Region													
NE	78	29	25	1,950	315	24,570	130	10,140	7	546	20	1,560	38,766
NC	93	17	3	279	258	23,994	68	6,324	4	372	28	2,604	33,573
S	89	22	87	7,743	247	21,983	34	3,026	7	623	23	2,047	35,422
W	53	17	135	7,155	551	29,203	90	4,770	16	848	36	1,908	43,884
Total				17,127		99,750		24,260		2,389		8,119	151,645
% Difference				13%		18%		2%		8%		20%	15%

VII

SUMMARY

The facts and figures generated by the city/county survey are abundant. There were nearly one hundred questions and over 350 respondents. Although the results generally did not produce striking new information, they did, however, document many facets of a local jurisdiction's efforts in 1972–heretofore only surmised.

These reported findings constitute only a portion of the information accumulated. All of the survey returns have been coded and stored for retrieval by computer; dependent upon the volume, requests for additional details can be answered to the extent that the confidentiality of individual respondents is not violated.

This summary will highlight those findings the authors view as suggestive of potential problem areas meriting further and more careful attention. These findings are organized by functional area rather than priority order.

TREATMENT

1. The responses from jurisdictions in the North Central region of the country were largely divergent from other regions throughout the treatment section. The proportion of patients in chemical treatment modalities (mostly methadone) was the highest of any region; the methadone programs had the highest proportion of minority enrollment; and the figures suggested that employment problems in methadone programs were most severe in this region. This combination of factors suggests two things: first, the figures need to be carefully verified; second, if they are indeed reflective the reasons for the situation should be investigated (see pages 5-11).

2. The survey identified nearly 1,000 methadone maintenance patients under the age of 18, a surprisingly large number. Projecting the identified survey population to the entire methadone maintenance population, we estimate between 3,000 and 4,000 methadone maintenance patients under 18 years of age. Since methadone is an addictive drug and should be used only for hard-core addicts with previous failures in abstinence programs, the decision to place minors on methadone maintenance is one that needs to be carefully considered (see page 7).

3. The role of civil commitment was most heavily emphasized by the smaller jurisdictions. Although the survey does not suggest why this is so, one possible explanation is that these communities experienced an excess treatment capacity and sought new and non-voluntary enrollment mechanisms. Overall, both the cities and counties reported that 80% of their patients in treatment had entered voluntarily. If the above hypothesis is correct, attention should be directed to changes in this proportion as the larger cities develop excess treatment capacity (see page 5).

4. The survey identified nearly $5,000,000 being spent annually for urinalysis monitoring of 23,000 methadone patients. Projected to the entire methadone maintenance population, the estimated annual expenditure is $15-20 million. The practice of urinalysis is not confined to treatment programs: a trend seems to be developing in its use as an early detector of drug use and as a measure of employability. We believe that these expenditures are a questionable addition to an already very large "drug abuse industrial complex," especially when one considers that many of the premises on which urinalysis has been based are now being reevaluated (see pages 10-11).

5. Employment rates among individuals enrolled in state, city and county operated methadone maintenance programs were found to be very low. This is particularly disturbing in view of the importance of employment to the rehabilitative process. This low employment rate is in part due to the generally unconcerned or resistant attitude of private sector employers. While this factor is largely outside the control of the treatment programs, those localities which had developed special employment programs for rehabilitated drug users did indicate that private employers were somewhat more favorably disposed (see pages 7-9).

EDUCATION AND PREVENTION

1. One of the most common drug education tools used by the public schools were films and audiovisuals. A cautionary note must be sounded in view of the recently published film evaluations conducted by the National Coordinating Council on Drug Education and sponsored by The Drug Abuse Council. Only 16% of the 220 films reviewed were classified as "scientifically and conceptually accurate"[10] (see page 14).

2. The response of many public school systems to student drug use was disturbing. In particular three actions stand out (see pages 14-15):

- The large number of school systems disrupting a student's education for possession of marijuana.
- The frequent failure of the school systems to distinguish between marijuana and heroin.
- The relative frequency with which the public schools refer students in drug possession cases to the police rather than to treatment programs.

The credibility of a school to educate students in any manner about the nonmedical use and misuse of drugs will be quickly challenged as hypocritical by a student body that itself often knows the difference between marijuana and heroin better than the school administrators seemingly do. In particular, the disruption of a student's education for the possession of marijuana is a punitive measure, not a rehabilitative or educational one. We question whether such a function is a proper one for the public school systems to assume.

LAW ENFORCEMENT

1. In the reporting cities and counties, over 60,000 arrests were made for the possession of marijuana during a twelve-month period. The enormity of this figure makes even more pressing the suggestion that further research into the social and economic costs of marijuana enforcement is needed (see page 18).

2. While many jurisdictions provided statistics on the number of arrests for possession and sale of marijuana and heroin, few provided statistics on the outcomes of these arrests. In view of the renewed emphasis on prevention of drug abuse through law enforcement, this void is most unfortunate. Such information is essential to describe accurately the flow of drug users and sellers through the criminal justice system—an essential first step in evaluating that system (see page 18).

ADMINISTRATION AND COORDINATION

1. A close working relationship between local jurisdictions and the states is all but dictated by P.L. 92-255. Our findings do not show strong patterns of agreement or disagreement between these governmental entities on the questions of local financial dependency or on local retention of policy formulation. Hopefully, as the roles of the state drug abuse program coordinators become more established, the state-local relationships will improve and their perceptions of each other will mesh (see pages 23-24).

2. The conduct of a local government's drug abuse efforts is heavily reliant upon the advice and assistance of the state and federal government. Yet, the local jurisdictions responding to our survey did not express widespread satisfaction with either level of government. The tables in Appendix C fully depict this situation. *The Federal Strategy for Drug Abuse and Drug Traffic Prevention, 1973* makes clear the central role to be assumed by the states. Based upon our survey findings it would seem that further attention needs to be directed toward the expressions of discontent made by many local jurisdictions (see pages 82-83).

[10] *Drug Abuse Films* (Washington, D.C.: National Coordinating Council on Drug Education, 1973).

APPENDIX A:

FORWARDING LETTER

AND QUESTIONNAIRE

1140
Connecticut
Avenue
Northwest
Washington DC
20036

Area Code 202
293-2200

International
City
Management
Association

Dear Local Drug Abuse Program Coordinator:

Drug abuse has become a major concern of local governments throughout the country. In order to successfully combat drug abuse, local officials need technical assistance and access to current information concerning other local experiences in treatment, rehabilitation, and education, as well as developments at the state and federal level.

For this reason, the International City Management Association and the Drug Abuse Council, an organization sponsored by a consortium of four major foundations are jointly conducting a survey of local drug abuse programs and policies. Copies of the survey are being sent to all cities over 50,000 and all counties over 100,000 population. A similar survey has been sent to the state governments.

Although the enclosed questionnaire is lengthy, your cooperation is needed to assure accurate and comprehensive returns. The questionnaire is in four parts: the section on green paper concerns Drug Coordination and Funding; the section on blue paper, Treatment and Rehabilitation; the section on beige paper, Education; and, the section on white paper, Law Enforcement. It is possible that there is one person in your jurisdiction qualified to answer all four sections; if not, you may want to distribute the sections to the appropriate agency or department. To expedite responses, we have enclosed four business reply envelopes in the event that completing the questionnaire will require returns from four separate agencies or individuals. We must emphasize the importance of a complete response from your jurisdiction to guarantee the success of the survey.

Results of the survey will be made available to all respondents. If you have any questions or comments, please do not hesitate to contact either Mary Ann Allard of the International City Management Association (1140 Connecticut Avenue, N.W., Washington, D.C. 20036, Ph. 202-293-2200) or Peter Goldberg of the Drug Abuse Council (1828 L Street, N.W., Washington, D.C. 20036, Ph. 202-785-5200).

Thank you for your assistance.

Sincerely yours,

Mark E. Keane
Executive Director
International City
Management Association

Thomas E. Bryant, M.D.
President
Drug Abuse Council

1140
Connecticut
Avenue
Northwest
Washington DC
20036

Municipal Year Book

Urban Data Service

International
City
Management
Association

Local Government Drug Abuse Programs – 1972

DEFINITION: The term "drug abuse prevention function" means any program or activity relating to drug abuse education, training, treatment, rehabilitation, or research, and includes any such function even when performed by an organization whose primary mission is in the field of drug traffic prevention functions, or is unrelated to drugs.*

TREATMENT AND REHABILITATION

1. Does your jurisdiction have a 24-hour hot line? ..... YES ( ) NO ( ) 7

2. Are drug treatment and rehabilitation programs currently in operation within your jurisdiction? ..... YES ( ) NO ( ) 8

3. Are any drug treatment and rehabilitation programs operated *by* your jurisdiction? ..... YES ( ) NO ( ) 9

4. What methods are used to make known the availability of these programs? (Check all applicable items)

10-_____a. Mailed brochures

11-_____b. Radio and television commercials

12-_____c. Billboard advertisements

13-_____d. Referrals from correctional system

14-_____e. Information through school system

15-_____f. Other (please specify): _____

*Defined as such in sec. 103 of PL 92-255

5. How many regular users of heroin (using at least six times per month) are currently enrolled in a drug treatment and rehabilitation program within your jurisdiction? ..... _____ 16-20

   Does this number of enrollees include those in private treatment programs? ..... YES ( ) NO ( ) 21

6. Approximately what percentage of these users are enrolled for the following reasons? (Please check primary reason only, if possible.)

   a. Voluntarily ..... _____% 22-24
   b. Civil commitment ..... _____% 25-27
   c. Criminal commitment ..... _____% 28-30
   d. Pretrial diversion ..... _____% 31-33
   e. Other (specify): _____ ..... _____% 34-36

   TOTAL 100%

7. Approximately what percentage of treatment and rehabilitation programs are funded by the following sources?

   a. Federal ..... _____% 37-39
   b. State ..... _____% 40-42
   c. Local ..... _____% 43-45
   d. Private ..... _____% 46-48
   e. Other (specify): _____ ..... _____% 49-51

   TOTAL 100%

8. How many people are currently enrolled in the following treatment modalities?

   a. Therapeutic communities ..... _____ 52-56
   b. Methadone maintenance ..... _____ 57-61
   c. Narcotic antagonists ..... _____ 62-66
   d. Outpatient abstinence ..... _____ 67-71
   e. Inpatient abstinence ..... _____ 7-11
   f. Detoxification ..... _____ 12-16
   g. Other (specify): _____ ..... _____ 17-21

   Do these figures include people enrolled in private treatment programs? ..... YES ( ) NO ( ) 22

9. Are methadone maintenance programs currently in operation in your jurisdiction?.... YES ( ) NO ( ) 23

   If "NO," please sign this section of the survey and return.

10. Please define the process one must go through in order to obtain *local* approval to dispense methadone. _____

_____

_____

_____

_____

11. Does your jurisdiction endorse or fund a methadone maintenance program currently in operation? . . . . . YES ( ) NO ( ) 24

12. Please indicate the number of patients currently enrolled in methadone maintenance . . _____ 25-29

13. Please indicate the approximate distribution by percentage of the ages of the patient population.

a. Below 18 years . . . . . _____% 30-32

b. 18 – 21 years . . . . . _____% 33-35

c. 22 – 30 years . . . . . _____% 36-38

d. 31 – 40 years . . . . . _____% 39-41

e. Over 40 years . . . . . _____% 42-44

TOTAL 100%

14. What is the percentage of males in the patient population? . . . . . _____% 45-47

15. Please indicate the approximate distribution by percentage of the races of the patient population.

a. White . . . . . _____% 48-50

b. Puerto Rican . . . . . _____% 51-53

c. American Indian . . . . . _____% 54-56

d. Black . . . . . _____% 57-59

e. Mexican American . . . . . _____% 60-62

f. Other (specify): _____ . . . . . _____% 63-65

TOTAL 100%

16. What are the admission requirements to methadone maintenance programs?

66-_____ a. Minimum age (please indicate age _____) 72-73

67-_____ b. Years of addiction (please indicate number of years _____) 74-75

68-_____ c. Proof of addiction

69-_____ d. Failures in abstinence (please indicate number _____) 76-77

70-_____ e. Place of residence

71-_____ f. Other (specify): _____

17. Do you currently have a waiting list for the methadone maintenance program? ..... YES ( ) NO ( ) 7

If "YES,"

1. How many are on the waiting list? ..... _____ 8-12

2. What is the present average length of time spent on the waiting list before admission to the program is secured? ..... _____ weeks 13-14

3. Approximately what percent drop off the list before admission to the program is secured? ..... _____ % 15-16

18. Must patients report for their methadone dosages daily? ..... YES ( ) NO ( ) 17

19. How long must a patient be enrolled in a methadone maintenance program before he is allowed to take home more than a daily supply of methadone? ..... _____ weeks (18-19)

20. How often must patients submit urine samples? (no. per week) ..... _____ 20

21. What percent of these samples are actually analyzed? ..... _____ % 21-23

22. What is the cost per analysis? ..... _____ 24-26

23. What action is taken on positive samples? _____

_____

_____

_____

24. How many of the methadone patients are presently employed? ..... _____ 27-31

25. How many methadone patients are currently receiving the following ancillary services?

a. Vocational training and counseling ..... _____ 32-36

b. Family counseling ..... _____ 37-41

c. Educational programs ..... _____ 42-46

d. Individual therapy ..... _____ 47-51

e. Group therapy ..... _____ 52-56

f. Other (specify): _____ ..... _____ 57-61

26. How many people are employed to administer the methadone program?

a. Full-time paid professional ..... _____ 62-64

b. Part-time paid professional ..... _____ 65-67

c. Full-time paid non-professional ..... _____ 68-70

d. Part-time paid non-professional ..... _____ 71-73

e. Volunteer ..... _____ 74-76

27. Have any attempts been made to measure the effectiveness of the methadone program? ..... YES ( ) NO ( ) 77

If "YES," please describe the method used to evaluate the effectiveness and the results. _____

_____

_____

_____

_____

_____

28. Has your jurisdiction developed a comprehensive plan for drug abuse programs? ..... YES ( ) NO ( ) 78

If "YES," please describe. _____

_____

_____

_____

_____

29. Please identify the director of the treatment and rehabilitation program.

Name _____

Title _____

Address _____

_____

_____

Please feel free to offer any general comments you may wish. Areas of interest might include but are not limited to:

a. level of satisfaction with your city's response to the drug abuse problem

b. areas of response most in need of improvement

c. restraints (physical, legal, social, economic) preventing you from more effectively responding

d. suggestions for future activities for the federal government, the Drug Abuse Council or the International City Management Association.

Name _____ Title _____

THANK YOU!

Municipal Year Book

Urban Data Service

1140 Connecticut Avenue Northwest Washington DC 20036

International City Management Association

Local Government Drug Abuse Programs – 1972

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EDUCATION

1. Does the public school system in your jurisdiction provide any educational program designed to affect student's attitudes toward drug use and abuse? . . . . . YES ( ) NO ( ) 7

   If "NO," please sign this section of the survey and return.

2. Is this program labeled a "drug education program?" . . . . . YES ( ) NO ( ) 8

3. What is your annual local budget for drug abuse education? . . . . . $_____ 9-14

   Which of the following federal agencies are supplying funds for these purposes?

Agency	Amount
a. Office of Education	$_____ 15-20
b. National Institute of Mental Health	$_____ 21-26
c. National Clearinghouse for Drug Abuse Information	$_____ 27-32
d. Law Enforcement Assistance Administration	$_____ 33-38
e. Bureau of Narcotics and Dangerous Drugs	$_____ 39-44
f. Office of Economic Opportunity	$_____ 45-50
g. Other (please specify): _____	$_____ 51-56

*Defined as such in sec. 103 of PL 92-255.

4. What best describes the educational approach used in your schools? (Check all applicable)

57-_____ a. Value orientation
58-_____ b. Decision making
59-_____ c. Information
60-_____ d. Psycho-social orientation
61-_____ e. Problem solving
62-_____ f. Other (specify): _____

Does the public school in your jurisdiction have a uniform drug education policy? . . . . YES ( ) NO ( ) 63

If "YES," does one person have overall responsibility for administering the drug education program? . . . . . YES ( ) NO ( ) 64

If "YES,"

1. Is this person's salary paid for by:

65-_____ 1. School system
_____ 2. Local jurisdiction
_____ 3. Both

2. What is the title and address of the administrator of the program?

Name _____
Title _____
Address _____

3. To whom does the administrator report?

66-_____ 1. School board
_____ 2. School administrator
_____ 3. Mayor/county executive
_____ 4. Local governing body
_____ 5. Manager/chief administrator
_____ 6. Police chief
_____ 7. Other (specify): _____

5. Are drug education courses required by:

67-_____ 1. Municipal law
_____ 2. State law

6. Who in the school system has responsibility for programming drug educational courses? (Check all applicable)

68-_____ 1. Classroom teacher
69-_____ 2. Biology teacher
70-_____ 3. Health or physical education teacher
71-_____ 4. Guidance counselor
72-_____ 5. Program is integrated: each instructor is responsible for relating course of study to drug abuse

7. How is information on drugs usually presented? (Check all applicable)

7-_____ 1. Standardized curricula
8-_____ 2. Assemblies
9-_____ 3. Lectures by experts
10-_____ 4. Films and audiovisuals
11-_____ 5. Student initiated research
12-_____ 6. Group discussions
13-_____ 7. Field trips
14-_____ 8. Other (specify): _____

8. Are teachers who are responsible for drug education courses trained? ..... YES ( ) NO ( ) 15

If "YES,"

1. Who finances the training? _____

2. How long is the initial training period? (State in weeks) ..... _____ 16-17

3. How often are refresher courses required? (Check one)

18-
_____ a. every month
_____ b. every 6 months
_____ c. every year
_____ d. other (specify) _____

9. Do students actively participate in formulating drug related school policies and educational programming? ..... YES ( ) NO ( ) 19

10. At what grade level is curriculum introduced? ..... _____ 20-21

11. What is the average number of hours per week per student devoted to drug related curriculum? ..... _____ hours 22-23

12. What sources are utilized for course materials? (Check all applicable)

24-_____ 1. State Department of Education
25-_____ 2. Publisher
26-_____ 3. Teachers develop their own
27-_____ 4. Commercial firm
28-_____ 5. Another local or state school system
29-_____ 6. Federal Government (specify agency): _____
30-_____ 7. Other (specify): _____

13. Are course materials modified for minority students? ..... YES ( ) NO ( ) 31

14. Are guidance counselors trained to be available to students for individual consultation about drugs? ..... YES ( ) NO ( ) 32

If "YES,"

1. Where are they trained? ..... _____

2. How long is the initial training period? (State in weeks) _____ 33-34

3. How often are refresher courses required? (Check one)

35-
_____ a. every month
_____ b. every 6 months
_____ c. every year
_____ d. other (specify) _____

4. What is the ratio of counselors to students? ..... _____ to _____ (36-40) (41-45)

5. How many hours per week is each counselor available for drug consultation? ..... _____ 46-47

6. Are teachers allowed to extend the privilege of confidentiality to students? ..... YES ( ) NO ( ) 48

7. Do counselors normally make referrals in acute cases? ..... YES ( ) NO ( ) 49

15. What is the usual high school action regarding a student in the following situations?

	Possessing marijuana	Selling marijuana	Possessing heroin	Selling heroin
No action	_____ (50)	_____ (51)	_____ (52)	_____ (53)
Suspension	_____ (54)	_____ (55)	_____ (56)	_____ (57)
Dismissal	_____ (58)	_____ (59)	_____ (60)	_____ (61)
Informing parents	_____ (62)	_____ (63)	_____ (64)	_____ (65)
Referral for treatment	_____ (66)	_____ (67)	_____ (68)	_____ (69)
Referral to police	_____ (70)	_____ (71)	_____ (72)	_____ (73)

16. Are there education/training courses offered to adult groups? . . . . . YES ( ) NO ( ) 7

If "YES,"

1. To which groups are these courses offered? (Check all applicable)

8-_____ 1. Police
9-_____ 2. Parents
10-_____ 3. School administrators
11-_____ 4. Politicians
12-_____ 5. Businessmen
13-_____ 6. Civic groups
14-_____ 7. All interested groups

2. Are these courses provided by the school system? . . . . . YES ( ) NO ( ) 15

17. Are there education/prevention programs outside the public school system? . . . . . YES ( ) NO ( ) 16

If "YES,"

1. Who conducts the programs? _____

2. What are the funding sources for the program? _____

_____

_____

3. Are they "outreach" oriented? . . . . . YES ( ) NO ( ) 17

4. Do they receive cooperation from the public school system? . . . . . YES ( ) NO ( ) 18

18. Has your jurisdiction developed a comprehensive plan for drug abuse programs? . . . . . YES ( ) NO ( ) 19

If "YES," please describe. _____

_____

_____

_____

Please feel free to offer any general comments you may wish. Areas of interest might include but are not limited to:

a. level of satisfaction with your city's response to the drug abuse problem

b. areas of response most in need of improvement

c. restraints (physical, legal, social, economic) preventing you from more effectively responding

d. suggestions for future activities for the federal government, the Drug Abuse Council or the International City Management Association.

Name _____ Title _____

THANK YOU!

Municipal Year Book

Urban Data Service

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International City Management Association

Local Government Drug Abuse Programs – 1972

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LAW ENFORCEMENT

1. Is there a special narcotics unit within the local police force? . . . . . YES ( ) NO ( ) 7

If "YES,"

1. In what year was this unit first established? . . . . . 19_____ 8-9
2. Who is the head of this division and what is his address?

Name _____

Address _____

_____

_____

_____

3. To whom does the head of the narcotics division directly report? (Check one)

10-

_____ 1. Police Chief

_____ 2. Assistant police chief

_____ 3. Public safety commission

_____ 4. Sheriff

_____ 5. Mayor/county executive

_____ 6. Chief administrator/manager

4. What is the annual budget for this division for the last fiscal year? . . . . . $_____ 11-16
5. How many officers are assigned to the narcotics division full-time? . . . . . _____ 17-19
6. How many patrolmer. are assigned to the narcotics division full-time? . . . . . _____ 20-22

*Defined as such in sec. 103 of PL 92-255.

2. Please complete the following chart regarding arrests and convictions for sale and possession in your jurisdiction during the past 12 months.

	Sale of heroin	Possession of heroin	Sale of marijuana	Possession of marijuana
a. Number of arrests during past 12 months . . .	(23-27)	(28-32)	(33-37)	(38-42)
b. Number arrested but directed to treatment before prosecution	(43-47)	(48-52)	(53-57)	(58-62)
c. Number of prosecutions.	(63-67)	(68-72)	(7-11)	(12-16)
d. Number of convictions	(17-21)	(22-26)	(27-31)	(32-36)
e. What was the average duration of sentence?	(37-39)	(40-42)	(43-45)	(46-48)
f. Maximum sentence given during the past 12 months	(49-51)	(52-54)	(55-57)	(58-60)

3. How long does it presently take from the time of arrest in a heroin possession or sale case to the time of trial? (State in months) . . . . . _____ 61-62

4. What percentage of the heroin possession and sale cases are resolved through "plea bargaining?" . . . . . _____ % 63-64

5. What treatment options are available to an addict prior to conviction of a crime within your jurisdiction?

_____

_____

_____

6. How many state drug enforcement officials are assigned to your jurisdiction? . . . . . _____ 65-67

7. How many federal drug enforcement officials are assigned to your jurisdiction? . . . . . _____ 68-70

8. How much heroin was confiscated within your jurisdiction during the past 12 months? . . . . . _____ lbs. 71-75

9. How much marijuana was confiscated within your jurisdiction during the past 12 months? . . . . . _____ lbs. 7-11

10. Is your local police force currently participating in any intergovernmental or interjurisdictional agreements related to narcotics law enforcement? . . . . . YES ( ) NO ( ) 12

If "YES," please describe briefly. _____

_____

_____

_____

_____

11. Has your jurisdiction developed a comprehensive plan for drug abuse programs? . . . . . YES ( ) NO ( ) 13

If "YES," please describe. _____

_____

_____

_____

_____

_____

Please feel free to offer any general comments you may wish. Areas of interest might include but are not limited to:

a. level of satisfaction with your city's response to the drug abuse problem

b. areas of response most in need of improvement

c. restraints (physical, legal, social, economic) preventing you from more effectively responding

d. suggestions for future activities for the federal government, the Drug Abuse Council or the International City Management Association.

Name _____ Title _____

THANK YOU!

Municipal Year Book
Urban Data Service

1140 Connecticut Avenue Northwest Washington DC 20036

International City Management Association

Local Government Drug Abuse Programs – 1972

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A. DRUG COORDINATION AND FUNDING

1. Does your jurisdiction have a person with overall responsibility either part-time or full-time for coordinating or guiding your local government's response to the drug abuse problem? ..... YES ( ) NO ( ) 7

2. What is the title and address of the person responsible for coordinating drug abuse programs?

Name _____

Title _____

Address _____

_____

_____

3. Is the coordinator's drug abuse function a full-time responsibility? ..... YES ( ) NO ( ) 8

4. Is the drug coordinator's primary background in: (Check one)

9- _____ 1. Health and medicine

_____ 2. Law enforcement

_____ 3. Administration and management

_____ 4. Other (specify): _____

*Define as such in sec. 103 of PL 92-255.

5. Has the coordinator had any prior experience in dealing with drug abuse? . . . . . YES ( ) NO ( ) 10

If "YES," please describe prior experience. _____

_____

_____

_____

6. To whom in the local government structure does the drug coordinator directly report? (Check one)

11- _____ 1. Mayor/county executive

_____ 2. Local governing body

_____ 3. Manager/chief administrator

_____ 4. Police chief/sheriff

_____ 5. Other (please specify): _____

_____

7. Does the coordinator have a professional supporting staff? . . . . . YES ( ) NO ( ) 12

If "YES," how many professional supporting staff are there (to the nearest one-half man-year)? . . . . . _____ (13-15)

8. What was the annual budget of the coordinating agency for the last fiscal year? . . . . . $_____ (16-21)

Please give the dates of the fiscal year for this budget. (Show month/year to month/year.) . . . . . / (22-23) to / (24-25)

9. Please define to the best extent possible, the structural relationship between the coordinating agencies and the various drug programs.

Drug programs	Structural relationship: Communication and liaison	Policy control	Management control	Budgetary control	Does not exist in local jurisdiction
a. Public education system's drug program . .	_____ (26)	_____ (27)	_____ (28)	_____ (29)	_____ (30)
b. Local law enforcement agency's narcotics control program	_____ (31)	_____ (32)	_____ (33)	_____ (34)	_____ (35)
c. Municipal sponsored drug treatment program	_____ (36)	_____ (37)	_____ (38)	_____ (39)	_____ (40)
d. Private drug treatment programs	_____ (41)	_____ (42)	_____ (43)	_____ (44)	_____ (45)

10. Does the coordinator or coordinating agency make an annual report on the state of the drug abuse problem and your local government's efforts to control it? . . . . . YES ( ) NO ( ) 46

If "YES," to whom is the report submitted? (Check one)

47- _____ 1. Mayor/county executive

_____ 2. Local governing body

_____ 3. Manager/chief administrator

_____ 4. Police chief/sheriff

_____ 5. Other (please specify): _____

_____

Please send a copy of the report if available.

11. If you had to make a rough estimate of the number of regular users of heroin (defined as using 6 times a month) in your local jurisdiction, what would you guess it to be? . . . _____ 48-52

Is this estimate basically an intuitive guess? . . . . . YES ( ) NO ( ) 53

If "NO," please explain the basis used to arrive at this estimate: _____

_____

_____

_____

12. How would you characterize the generally prevailing attitude among employers in your jurisdiction towards hiring former drug abusers? (Check one)

54-
_____ 1. Enthusiastic

_____ 2. Cooperative

_____ 3. Have shown little concern

_____ 4. Resistant

_____ 5. Absolutely opposed to hiring rehabilitated drug abusers

13. Is your jurisdiction actively engaged in special programs to hire rehabilitated drug abusers? . . . . . YES ( ) NO ( ) 55

14. Please indicate your local government's relationship with the state and federal governments in dealing with the drug abuse problem in the following areas:

a. Funding:

Very good 1 / 2 / 3 / 4 / 5 Not good 56

b. Technical assistance:

Very good 1 / 2 / 3 / 4 / 5 Not good 57

c. Communication:

Very good 1 / 2 / 3 / 4 / 5 Not good 58

d. Accessibility:

Very good 1 / 2 / 3 / 4 / 5 Not good 59

15. Have you been satisfied with your local government's relationship with the state government in the area of drug abuse? . . . . . YES ( ) NO ( ) 60

16. Have you been satisfied with your local government's relationship with the federal government in the area of drug abuse? . . . . . YES ( ) NO ( ) 61

17. Which of the following statements would best define the relationship of the local government to the state agency? (Check one)

62- _____ 1. Local government programs are heavily dependent upon state financial aid, and the state actively asserts policy control over local government programs.

_____ 2. Local government programs are heavily dependent upon state financial aid, but local governments operate their drug program relatively autonomously.

_____ 3. Local government programs are not heavily dependent upon state financial aid, but the state retains and actively asserts policy control over local government programs.

_____ 4. Local government programs are not heavily dependent upon state financial aid and they operate autonomously.

18. Has your jurisdiction developed a comprehensive plan for drug abuse programs? ..... YES ( ) NO ( ) 63

B. FUNDING

19. How much total money is estimated to be spent annually within your jurisdiction for drug abuse response? ..... $ _____ (64-69)

20. What percentage of funds are received from the following sources?

Local jurisdiction	_____ %	70-72
State	_____ %	73-75
Federal	_____ %	7-9
Private sources	_____ %	10-12
Other (please specify): _____	_____ %	13-15
TOTAL	100%	

21. What percentage of the funds are expended for the following functions?

Law enforcement	_____ %	16-18
Treatment and rehabilitation	_____ %	19-21
Education prevention and training	_____ %	22-24
Research	_____ %	25-27
Planning and coordination	_____ %	28-30
Other (please specify): _____	_____ %	
TOTAL	100%	

22. In what year were funds first specifically allocated in your local budget for drug abuse response? ..... 19_____ (31-32)

23. During the past 12 months, has any federal agency rejected a request for funding for drug abuse programs? ..... YES ( ) NO ( ) 33

If "YES," please indicate if available which agency rejected the funding, and the amount of funds requested.

Agency	Amount requested
_____	$ _____ 34-39
_____	$ _____ 40-45
_____	$ _____ 46-51
_____	$ _____ 52-57

Please feel free to offer any general comments you may wish. Areas of interest might include but are not limited to:

a. level of satisfaction with your city's response to the drug abuse problem

b. areas of response most in need of improvement

c. restraints (physical, legal, social, economic) preventing you from more effectively responding

d. suggestions for future activities for the federal government, the Drug Abuse Council or the International City Management Association.

Name _____ Title _____

THANK YOU!

APPENDIX B:

SURVEY RESPONSE RATES

Table 1.
Survey Response Rates
by Size and Region

Table 1

Survey Response Rates by Size and Region

	Total Surveyed	Respondents							
		Treatment & Rehabilitation		Education		Law Enforcement		Coordination & Funding	
		#	%	#	%	#	%	#	%
CITIES	409	227	56	235	57	238	58	229	56
Population:									
over 500,000	26	14	54	16	62	17	65	15	58
250,000-500,000	30	23	77	21	70	25	83	23	77
100,000-250,000	98	57	58	58	59	98	56	52	53
50,000-100,000	255	133	52	140	55	255	55	139	55
Region:*									
Northeast	102	47	46	49	48	46	45	48	47
North Central	108	62	57	62	57	61	56	62	57
South	103	60	58	63	61	72	70	55	53
West	96	58	60	61	64	59	61	64	67
COUNTIES	313	142	45	130	42	111	35	142	45
Population:									
over 500,000	58	33	57	26	45	24	41	33	57
250,000-500,000	70	32	46	29	41	26	37	32	46
100,000-250,000	185	77	42	75	41	61	33	77	42
Region:*									
Northeast	78	42	54	37	47	31	40	42	54
North Central	93	29	31	28	30	25	27	29	31
South	89	41	46	39	44	33	37	41	46
West	53	30	57	26	49	22	42	30	57

* Composition of Regions

Northeast:	North Central:	South:	West:
Connecticut	Illinois	Alabama	Alaska
Maine	Indiana	Arkansas	Arizona
Massachusetts	Iowa	Delaware	California
New Hampshire	Kansas	District of Columbia	Colorado
New Jersey	Michigan	Florida	Hawaii
New York	Minnesota	Georgia	Idaho
Pennsylvania	Missouri	Kentucky	Montana
Rhode Island	Nebraska	Louisiana	Nevada
Vermont	North Dakota	Maryland	New Mexico
	Ohio	Mississippi	Oregon
	South Dakota	North Carolina	Utah
	Wisconsin	Oklahoma	Washington
		Puerto Rico	Wyoming
		South Carolina	
		Tennessee	
		Texas	
		Virginia	
		West Virginia	

APPENDIX C:

SATISFACTION WITH STATE AND FEDERAL GOVERNMENTS

Table 2. Cities:
Population and Regional Breakdowns

Table 3. Counties:
Population and Regional Breakdowns

Table 2

Cities Satisfaction with State and Federal Governments

Overall

State \ Federal	Satisfied	Not Satisfied	Total
Satisfied	66 (42%)	24 (15%)	90 (57%)
Not Satisfied	16 (10%)	53 (33%)	69 (43%)
Total	82 (52%)	77 (48%)	159

Population

over 500,000	4 (36%)	1 (9%)	5 (45%)
	2 (18%)	4 (36%)	6 (55%)
	6 (55%)	6 (45%)	11
250,000 to 500,000	7 (37%)	0 (0%)	7 (37%)
	4 (21%)	8 (42%)	12 (63%)
	11 (58%)	8 (42%)	19
100,000 to 250,000	15 (43%)	8 (23%)	23 (66%)
	3 (9%)	9 (26%)	12 (34%)
	18 (51%)	17 (49%)	35
50,000 to 100,000	40 (43%)	15 (16%)	55 (59%)
	7 (7%)	32 (34%)	39 (41%)
	47 (50%)	47 (50%)	94

Region

NE	14 (36%)	9 (23%)	23 (59%)
	5 (13%)	11 (28%)	16 (41%)
	19 (49%)	20 (51%)	39
NC	16 (39%)	7 (17%)	23 (56%)
	4 (10%)	14 (34%)	18 (44%)
	20 (49%)	21 (51%)	41
S	16 (44%)	3 (8%)	19 (53%)
	4 (11%)	13 (36%)	17 (47%)
	20 (56%)	16 (44%)	36
W	20 (47%)	5 (12%)	25 (58%)
	3 (7%)	15 (35%)	18 (42%)
	23 (53%)	20 (47%)	43

Table 3

Counties Satisfaction with State and Federal Governments

State \ Federal	Satisfied	Not Satisfied	Total
Satisfied	44 (39%)	17 (15%)	61 (54%)
Not Satisfied	7 (6%)	44 (39%)	51 (46%)
Total	51 (46%)	61 (54%)	112

Population

over 500,000	13 (42%)	1 (3%)	14 (45%)
	2 (6%)	15 (48%)	17 (55%)
	15 (48%)	16 (52%)	31
250,000 to 500,000	9 (38%)	5 (21%)	14 (58%)
	3 (13%)	7 (29%)	10 (42%)
	12 (50%)	12 (50%)	24
100,000 to 250,000	22 (39%)	11 (19%)	33 (58%)
	2 (4%)	22 (39%)	24 (42%)
	24 (42%)	33 (58%)	57

Region

NE	10 (33%)	6 (20%)	16 (53%)
	3 (10%)	11 (37%)	14 (47%)
	13 (43%)	17 (57%)	30
NC	12 (50%)	2 (8%)	14 (58%)
	1 (4%)	9 (38%)	10 (42%)
	13 (54%)	11 (46%)	24
S	14 (45%)	6 (19%)	20 (65%)
	2 (6%)	9 (29%)	11 (35%)
	16 (52%)	15 (48%)	31
W	8 (30%)	3 (11%)	11 (41%)
	1 (4%)	15 (56%)	16 (59%)
	9 (33%)	18 (67%)	27

APPENDIX D:

LOCAL GOVERNMENT RELATIONSHIPS WITH STATE AND FEDERAL GOVERNMENTS

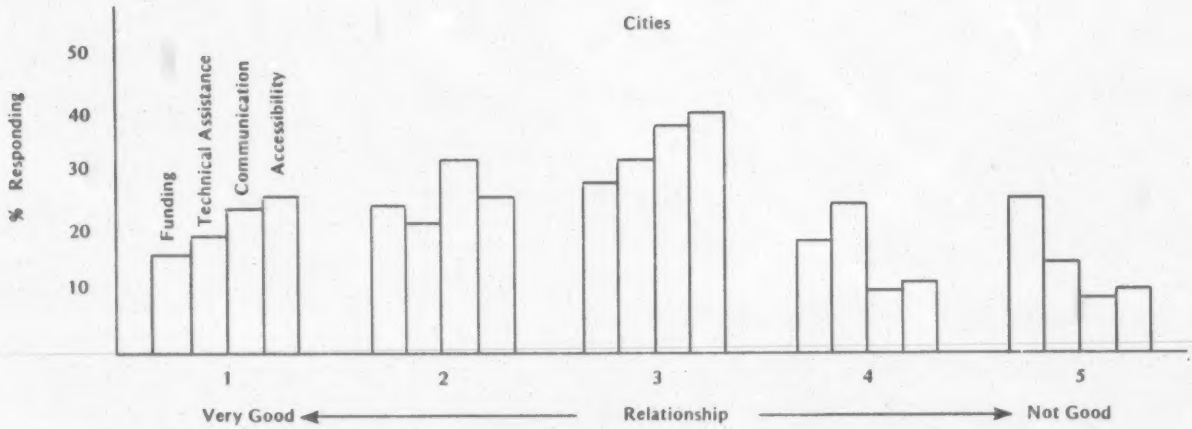
Figure 1. Overall Response:
Cities and Counties

Figure 2. Funding Relationships:
Population and Regional Breakdowns

Figure 3. Technical Assistance:
Population and Regional Breakdowns

Figure 4. Communication:
Population and Regional Breakdowns

Figure 5. Accessibility:
Population and Regional Breakdowns



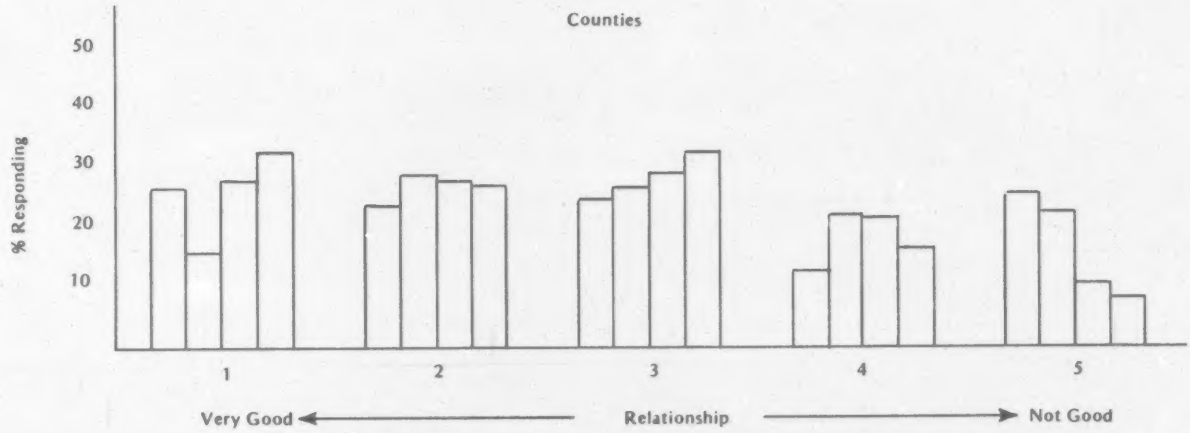
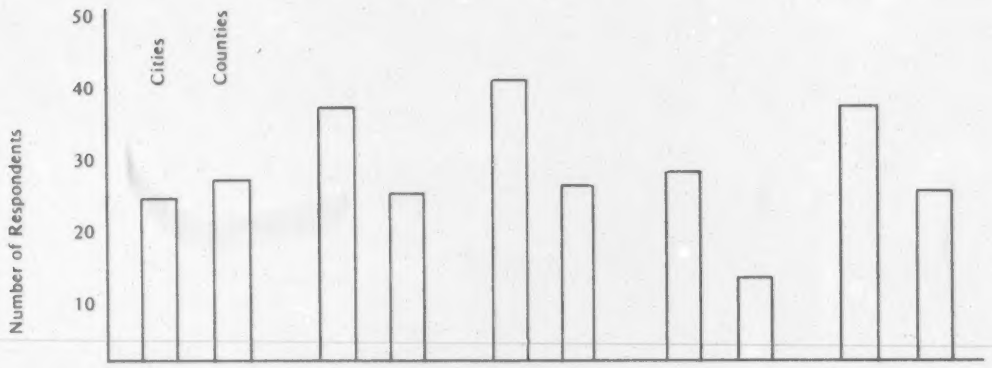
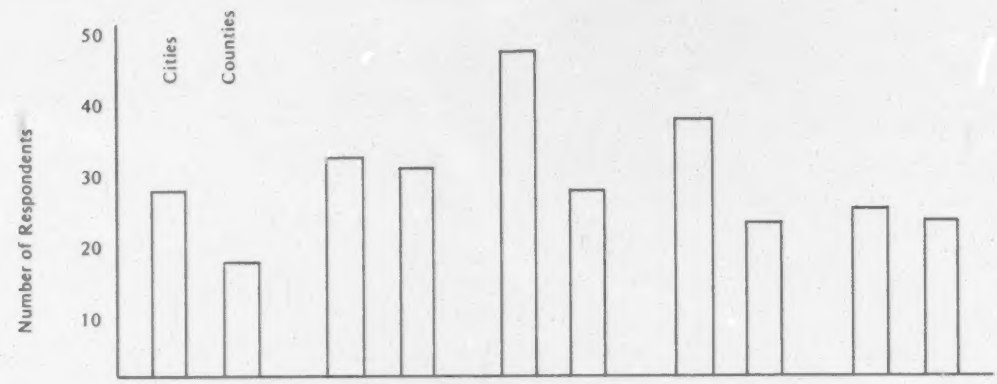


Figure 1. Local Government Relationships with State and Federal Governments



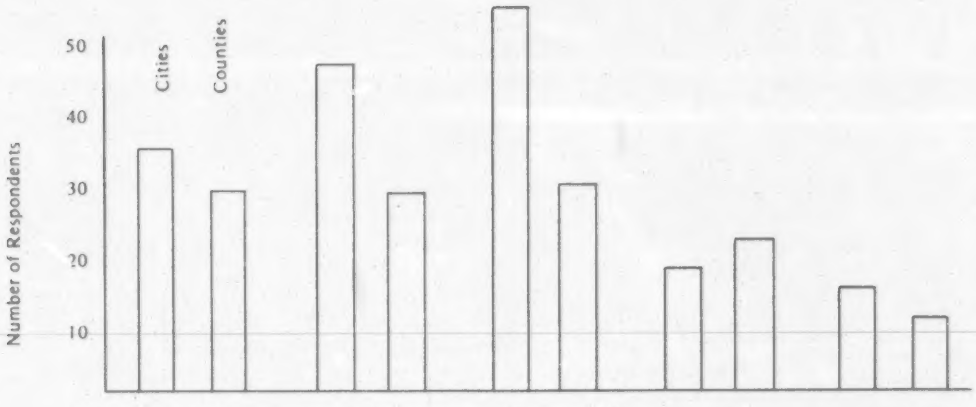
COMPOSITION	1 Very Good		2		3 Relationship		4		5 Not Good		Total Cities	Total Counties
Total	23	26	36	24	40	25	27	12	37	25	163	112
By Population												
over 500,000	1	5	3	7	2	9	4	4	1	4	11	29
250,000 to 500,000	2	8	4	6	6	2	3	2	5	7	20	25
100,000 to 250,000	5	13	11	11	10	14	6	6	6	14	38	58
50,000 to 100,000	15	–	18	–	22	–	14	–	25	–	94	–
By Region:												
Northeast	7	11	6	10	9	3	8	2	8	8	38	34
North Central	5	6	11	2	9	7	8	5	11	2	44	22
South	3	6	10	4	8	8	6	3	12	9	39	30
West	8	3	9	8	14	7	5	2	6	6	42	26

Figure 2. Funding Relationships



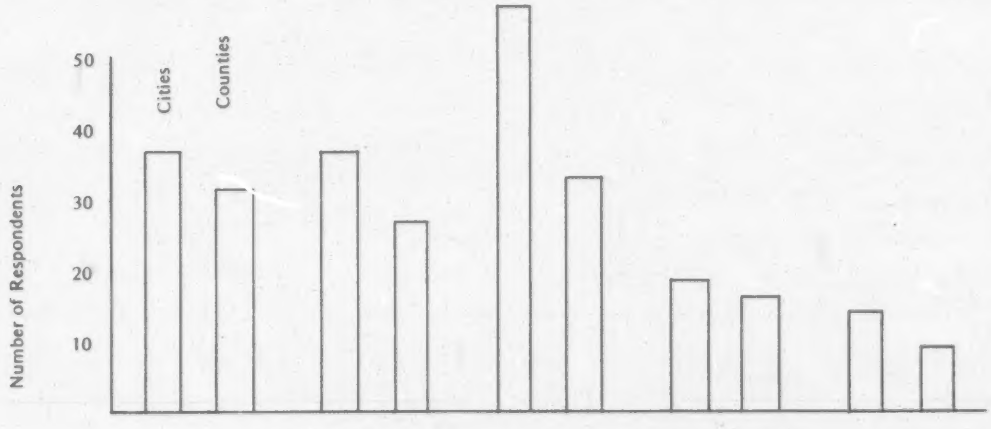
COMPOSITION	1 Very Good		2		3 Relationship		4		5 Not Good		Total Cities	Total Counties
Total	27	16	31	29	46	26	36	22	23	22	163	115
By Population												
over 500,000	1	3	0	10	5	5	5	7	1	5	12	30
250,000 to 500,000	1	2	6	9	8	4	3	4	2	6	20	25
100,000 to 250,000	5	11	8	10	10	17	8	11	6	11	37	60
50,000 to 100,000	20	–	17	–	23	–	20	–	14	–	94	–
By Region												
Northeast	7	5	7	9	11	9	9	6	4	7	38	36
North Central	10	4	8	8	10	4	10	4	7	3	45	23
South	4	4	6	4	14	7	8	7	5	8	37	30
West	6	3	10	3	11	6	9	5	7	4	43	26

Figure 3. Technical Assistance



COMPOSITION	Very Good				Relationship				Not Good		Total Cities	Total Counties
Total	34	28	46	28	54	29	17	21	14	11	165	117
By Population												
over 500,000	1	8	3	6	4	8	2	7	1	2	11	31
250,000 to 500,000	0	5	6	7	11	8	2	2	1	3	20	25
100,000 to 250,000	9	15	13	15	10	13	5	12	1	6	38	61
50,000 to 100,000	24	–	24	–	29	–	8	–	11	–	96	–
By Region												
Northeast	6	8	12	10	18	8	2	6	1	4	39	36
North Central	14	7	14	8	10	3	3	4	4	2	45	24
South	6	8	7	3	16	10	6	6	4	4	39	31
West	8	5	13	7	10	8	6	5	5	1	42	26

Figure 4. Communication



COMPOSITION	Very Good				Relationship				Not Good		Total Cities	Total Counties
Total	37	32	37	27	57	33	18	16	14	8	163	116
By Population												
over 500,000	1	9	2	7	5	7	3	7	0	1	11	31
250,000 to 500,000	2	8	4	6	11	7	2	1	1	3	20	25
100,000 to 250,000	9	15	11	14	11	19	4	8	2	4	37	60
50,000 to 100,000	25	–	20	–	30	–	9	–	11	–	95	–
By Region												
Northeast	10	9	8	14	16	8	3	3	2	2	39	36
North Central	14	10	9	3	14	6	2	3	5	1	44	23
South	6	8	10	2	13	11	7	7	3	3	39	31
West	7	5	10	8	14	8	6	3	4	2	41	26

Figure 5. Accessibility

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The Publications Series of The Drug Abuse Council is offered as an informational service to organizations and individuals engaged in formulating and assessing public policies, operating programs and conducting research related to the nonmedical use of drugs in our society.

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- **Heroin Epidemics: A Quantitative Study of Current Empirical Data**

  One explanation of the spread of heroin use is provided through the application of mathematical models. The study provides a frame of reference for public policy analysis.

- **Methadone Maintenance: The Experience of Four Programs**

  Written for The Drug Abuse Council by journalist Paul Danaceau, this study is a descriptive analysis of the treatment process in clinics in New York City, Albequerque, East Boston and New Orleans, highlighting common issues, problems and needs.

- **Public Administration of Drug Programs ***

  Graham S. Finney recounts his experiences as former commissioner of New York City's Addiction Services Agency in this report. A useful primer for program administrators, operators and persons interested in public decision-making, the lengthy study includes chapters on planning, program linkages, intergovernmental relations, uses of technology and the "numbers game."

- **Survey of City/County Drug Abuse Activities 1972**

  A companion to the State Survey, this report describes drug abuse activites in cities and counties with populations exceeding 50,000 and 100,000 respectively. The study analyzes efforts in law enforcement, administration, education, treatment and rehabilitation.

- **Survey of State Drug Abuse Activities 1972**

  An analysis of state drug abuse activities including objectives, priorities and needs as reported by state drug abuse officials during 1972. Designed to yield general information on state efforts, the survey was conducted with the International City Management Association and National Association of State Drug Abuse Program Coordinators. Included are analyses by state size and geographic region.

- **The Organization of the United Nations to Deal with Drug Abuse**

  The origins of international drug controls and structure of the United Nations system form the background for this detailed study. Provided are analyses and summaries of core components of the United Nations including the Commission on Narcotic Drugs, Division of Narcotic Drugs, United Nations Fund for Drug Abuse Control, International Narcotics Control Board and World Health Organization.

- **The Retail Price of Heroin: Estimation and Applications**

  This summary of research designed to develop estimates of heroin retail prices in selected U.S. cities is applied to problems associated with illicit narcotics use. Extensions of the analysis to other policy-related questions including the effectiveness of law enforcement policies are discussed.

- **A Pilot Study of Occasional Heroin Users**

  A report on the psychological testing of 12 non-addicted heroin users. This reprint of an article published in the Archives of General Psychiatry is free of charge.

HANDBOOK SERIES

- **Accountability in Drug Education: A Model for Evaluation***

  Designed for use by educators, administrators and researchers, this manual provides step-by-step explanations of program planning and assessment, keyed to the reader's level of involvement. Arranged in "workbook" fashion are sections discussing goal selection and outcome measurement, including a compilation of recommended knowledge, attitude and behavior scales. Other sections provide useful information on the problems of test administration, considerations for scoring tests, and advice about using results to design more effective programs.

- **Community Guide for Drug Program Assessment ***

  This study prepared for The Drug Abuse Council by the Urban Institute describes how community leaders can obtain systematic information of local drug programs' effectiveness, relating this to the planning process.

- **High School Student Drug Education Research Project ***

  Nine student groups from across the country investigated illicit drug use in their local areas. Their findings and recommendations are detailed in this report. Problems encountered by the student researchers are also described.

BOOKS

- **Army Drug Abuse Program: A Future Model?**

  This follow-up study to FEDERAL DRUG ABUSE PROGRAMS focuses on one Federal agency's drug abuse efforts. The feasibility of replicating the military model is discussed. $2.

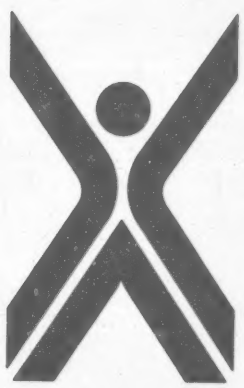
- **Dealing with Drug Abuse: A Report to the Ford Foundation**

  Published in 1972, by Praeger, Inc., this account of the two year survey project led to the formation of The Drug Abuse Council. Original findings, conclusions and recommendations are included. Background papers discuss treatment modalities, drug education, economics of heroin, drugs and their effects, altered states of consciousness, Federal drug abuse expenditures and the British drug control system. Available at your local bookstore.

- **Federal Drug Abuse Programs**

  A report to the American Bar Association and The Drug Abuse Council describing Federal drug abuse activities through July 1972. Analysis and recommendations regarding policies and programs are included. $15.

* Available after November 1, 1973.



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